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BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT

HEARINGS

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

S. 768

TO AMEND THE PUBLIC HEALTH SERVICE ACT AND THE FAIR LABOR STANDARDS ACT OF 1938 TO PROVIDE BASIC HEALTH BENEFITS FOR ALL AMERICANS, AND FOR OTHER PURPOSES

MAY 1 AND JUNE 23, 1989

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BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT

MONDAY, MAY 1, 1989

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:30 a.m., in Room 430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Hatch, Kassebaum, and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. We will come to order.

No issue is more important to the well-being of American families than access to health care at an affordable price. Sooner or later, almost every family confronts a serious illness for one of its members. And any family that lacks adequate health insurance can find the cost of care for that illness devastating. For millions of citizens, the state of their family's health is too often determined by the size of their wealth.

The statistics only begin to tell the story. Thirty-seven million Americans have no health insurance at all. Sixty million more have inadequate insurance that would not protect them against serious illness.

Every day, every year, more than 40,000 Americans seek health care and are turned away, or neglect health care they need because they know they cannot afford it.

Every week, more than 46,000 American families are faced with health care costs in excess of $3000 that insurance does not cover. For the vast majority of these families, such costs are truly catastrophic.

Across the country, more and more hospitals are facing a cruel choice between closing their doors to those who cannot pay and closing their doors to everyone because they can no longer afford to care for those in need.

The legislation we are considering today, the Basic Health Benefits for All Americans Act, would establish a progressive public-private partnership based on two simple concepts:

First, the job-based system of health insurance that has served the Nation well and provides good coverage for most worker and their families should be extended to the millions of other workers who have been left out of the present system. This simple step alone will provide coverage for 23 million workers and their dependents, two-thirds of the uninsured.

It has been more than half a century since we decided that every employer should be required to pay a minimum wage, to provide unemployment compensation, and to contribute to retirement insurance through social security. It has been a quarter of a century since we brought in social security to provide health insurance for the elderly under Medicare. In 1989, the time is long overdue to insist that every American that works for a living should have access to health insurance.

Second, the current Federal-State Medicaid program for low-income citizens should be expanded by the addition of a program to cover those who cannot benefit from employment-based insurance. Because of current budget pressures, this new public program would be phased in gradually, beginning in 1991 with the coverage for the six million uninsured Americans who are poor.

Together, these public and private programs will guarantee the basic health insurance protection that should be the birthright of every American, a right that has long since been secured by every other industrial country in the world except South Africa.

There is nothing partisan about this issue. Overwhelming majorities of the American people from both political parties in all regions of the country support it. Indeed, as one of our distinguished witnesses will testify, the Basic Health Benefits Act is very similar to the Comprehensive Health Insurance Act proposed by President Nixon and also supported by President Ford in the 1970's.

From virtually the day I first joined the Labor Committee in 1963, I believed that health care should be a basic human right. If I have any regrets in the course of this long battle, it is that we did not seize the moment in the 1970's when a bipartisan compromise seemed possible. But the window of opportunity closed in 1976. Thirteen years later, the question is whether we can finally open it again. With goodwill on both sides, I think we can because with each passing year the need becomes even more overwhelming.

One final point. We are not talking today about a system of socialized medicine or national health insurance based on the European model which places the responsibility for both financing and operating the system primarily on the Government. The mixed program I favor preserves the private system of job-based coverage for all those who are employed and relies on public coverage only for those who cannot work.

Our witnesses today will help us understand the dimensions of this problem and analyze the solution proposed in the Basic Health Benefits for All Americans Act. And I look forward to their testimony.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Today we renew the effort to bring essential health care to all our citizens.

This problem began a generation ago when the decision was made to enact Medicare for elderly Americans but not for all Americans. Today, almost all elderly Americans have access to affordable health care. Medicare has become one of the most popular social programs ever enacted. But the problem of denial of health care to other citizens has increased every year; it is a crisis now, and Congress can neglect it no longer.

Thirty-seven million Americans have no health insurance coverage at all, either public or private. Sixty million more have insurance that even the Reagan Administration said was inadequate.

Every day, every year, more than forty thousand Americans seek health care and are turned away, or neglect their health because they cannot afford the care they need.

Every week, more than 46,000 American families are faced with catastrophic health care costs in excess of $3,000 that their insurance does not cover.

Across the country, more and more hospitals are facing a cruel choice between closing their doors to those who cannot pay and closing their doors to everyone--because they can no longer afford to serve those in need.

To illustrate what these tragedies mean in human terms, I would like to tell you a tale of two children. Both developed cancer. Coby Howard was seven years old when he was diagnosed as having leukemia. His mother was a single parent of three children. Although she could have qualified for welfare, she preferred to work to support her family--and she worked hard, putting in long hours as a waitress for a modest wage.

When Coby's cancer was diagnosed, his mother was devastated. But there was hope, because the type of leukemia that afflicted Coby has a 70 percent cure rate if a bone marrow transplant is performed. But a transplant costs $100,000, and, unlike most of us, Coby's mother had no insurance through her job. Instead, the family relied on Medicaid, and in Oregon, Medicaid does not cover such high cost procedures.

The community responded. A fund-raising effort was launched to raise the $100,000. They had reached $80,000 when Coby died.

The second young man who developed cancer had a worse prognosis than Coby. But his family had access to the best medical care available without any consideration of cost. The stress of caring for that child and the concern about his survival was great, but at least his family could take comfort in knowing that everything that could be done was being done. He is alive and well today, and he is my son.

No other industrial country in the world except South Africa tolerates a system in which the state of a family's health is determined by the the amount of the family's wealth.

The legislation we are proposing today will assure that no man, woman or child in America will ever again be denied the health care they need. It will guarantee that no family will see its savings wiped out and its hopes for the future swept away by a tidal wave of debt because of inadequate or nonexistent health insurance.

The Basic Health Benefits for All Americans Act is not back door national health insurance. It creates no new bureaucracy. It constructs no massive regulatory apparatus.

This bill is built on two simple concepts. First, the job-based system of health insurance that provides coverage for most workers and their families should be extended to the millions of workers who have been left out. This simple step will provide coverage for 23 million people--two-thirds of the uninsured.

Second, Medicaid should be expanded by the addition of a new program to provide benefits for Americans not covered by the current program, and not eligible for job-based insurance. Because of current budget pressures, the public program will be phased in gradually, beginning in 1991 with the 6 million uninsured Americans who are poor. The second phase, beginning in 1996, will provide coverage to the near poor, with incomes above poverty but within 185 percent of the poverty line. The final phase, implemented in 1999, will provide coverage for all remaining uninsured citizens.

The public program will be financed by a combination of Federal-State funds and beneficiary premiums related to income, with Federal contributions based on the current Medicaid matching formula. Benefits will be essentially the same as the basic package required of employers, except that the cost-sharing and premiums will not be required for the poor, and will be reduced for the near poor.

The employer mandate program builds on the bill introduced in the last Congress, and reported by the Senate Labor Committee. Like the previous bill, the legislation requires firms to provide a basic package of benefits to employees working more than seventeen and a half hours a week and their families. The benefits include physician services, hospital services, diagnostic tests, pregnancy and well-baby care, and a limited mental health benefit.

The bill also sets maximum co-payments, deductibles, and the employee share of the premiums, and provides catastrophic coverage through an out-of-pocket limit on covered expenses. No exclusions for pre-existing conditions are permitted. The bill provides flexibility for employers by allowing them to vary the benefit package to suit their unique needs, as long as the basic benefits are covered and the value of the plan is not cut back.

A new feature in this year's bill allows firms to make a premium contribution proportional to hours worked for employees working less than 25 hours per week.

Two major concerns were expressed about last year's bill. First, it was said that the cost of providing health care would result in increased unemployment and be a drain on the national economy, as American businesses struggle to compete in world markets. This issue was examined carefully by the Labor Committee in an extensive series of hearings and was found to be

With regard to economic impact, four independent, credible economic analyses of the bill were conducted by distinguished authorities. The bill was tested using two of the best known models of the U.S. economy--the Wharton Model and the Decision Resources, Inc. model. Each of those analyses found that the impact of the bill on employment and economic growth would be negligible.

In fact, the legislation will help, not harm, American businesses in world markets. Ninety-seven per cent of the employees of the manufacturing firms that are at the cutting edge of international trade today already insure their workers. These businesses pay too much for health insurance because others pay too little.

There is no free lunch in health care or in health insurance. When hospitals provide charity care for someone who cannot pay, that care is hardly free. It results in higher health care charges to paying patients and higher premiums to firms that provide insurance.

It is time to put these hidden costs where they belong--on the firms that refuse to protect their workers' health. If we succeed in this endeavor, the country as a whole will be the winner, because a healthier, insured America will also be a more competitive America.

The second major concern expressed about the bill is its impact on small business. I, too, am determined to enact it in a way that will protect the interests of both small business and the American people.

The health insurance market for small businesses today is a disaster area. Firms with fewer than 25 workers pay a mark-up for coverage they buy that is five times as high as a large business would pay for the same benefits. For very small businesses of ten or fewer employees, the mark-up is eight times higher--approaching 40 percent of the total premium.

Not only is the cost of insurance to small business excessive, but it is frequently not available at any price; in other cases, it is available under conditions that render it of little value. In this market, particularly for firms with ten or fewer employees, if a worker or owner or a member of their family is in poor health, insurance will often not be available at all. When insurance is available, it will typically exclude coverage for pre-existing conditions--the very diseases for which they are most likely to need insurance. To add insult to injury, if a healthy group does manage to secure coverage and a member of the firm subsequently develops a costly illness, coverage is often not renewed or only offered again at an exorbitant price.

In light of the harsh realities of the marketplace, it is not surprising that many small firms choose not to provide health insurance coverage to their workers. What is surprising is that a majority of small business employees work for firms that do the decent thing and provide insurance, in spite of the exorbitant prices they pay in the marketplace.

It is also surprising to me that the small business lobby is firing at this this legislation, instead of at the victimization of millions of small business employers.

Our message to small business today is that government is on your side, and that there is no inherent conflict between small business and basic health insurance.

The Basic Health Benefits bill will restructure the small business insurance market by establishing a system of regional insurers. This system will give small businesses the benefits of economies of scale, guaranteed access to coverage, community rating, and availability of cost-effective managed care.

We have also included an important additional protection. Any small business that faces an excessive cost in providing health insurance coverage will receive a federal subsidy.

I believe that this legislation is one that small businesses can not only live with--it is one they can prosper under.

In companion legislation, we are also offering a proposal to improve the tax treatment of health insurance purchased by small business and that will dramatically simplify the so-called "Section 89 non-discrimination rules" that many firms, large and small, have found so burdensome. In fact, Section 89 will be largely unneccesary if Basic Health Benefits is enacted.

As I look back at the distance we have travelled over the last two years with this idea, I am impressed with the progress we have made.

Two years ago, there was little attention to the crisis in access to health care. Today, an article in the New England Journal of Medicine advocating a radical reform of our health care system has just received wide attention throughout the country.

Two years ago, few groups were willing to lend their name to this bill; for many, support was lukewarm at best. Today, we have more then 100 groups, drawn from all spectrums of society, willing to work hard to enact this proposal into law.

Three-quarters of the American people support the proposal--and the support is equally strong among citizens of all income levels, all races, all regions of the country, and in both political parties.

I look forward to working with the groups represented here today, with our other sponsors in Congress, and with millions of our fellow citizens. It is time to make health care a basic right for all, not just an expensive privilege for the few.

SENATOR EDWARD M. KENNEDY'S PROPOSED BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT (BHB)

THE PROBLEM

Rising number of uninsured Americans

Thirty-seven million Americans currently have no health insurance coverage -- and the number has been rising by almost a million a year since 1980. Approximately two-thirds of the uninsured (23 million) are **members of families** in which at least one member of the household **works full-time**. Children constitute one third of the uninsured (12 million children).

Inadequate insurance leaves millions vulnerable to catastrophic costs

Sixty million Americans have some insurance but they are underinsured. They have no catastrophic cap on their vulnerability to out-of-pocket health care costs and are potentially at risk in the event of serious illness.

Denial of essential care/Families unprotected against high costs

A recent report by the Robert Wood Johnson Foundation found that one million Americans annually are denied health care because they cannot pay for it; an additional fourteen million do not even seek care they feel they need because they know that they cannot afford it. A recent study found that up to one-third of hospital admissions could have been avoided by earlier access to care. According to the Department of Health and Human Services, about two-and-a-half million families annually face catastrophic, out-of-pocket health care expenses exceeding $3,000.

Excessive health insurance costs for large and small businesses

Businesses that already insure their workers pay a high price for the failure of all businesses to fulfill this social responsibility. As Robert Crandall, Chairman of American Airlines, said, "Companies like ours pay for health care twice -- once for our own employees and then again, via taxes and inflated health insurance premiums, for the employees of those businesses who don't provide benefits for their own people."

Small businesses who enter the insurance market pay unnecessarily high costs because the current fragmented, inefficient insurance system for small businesses produces high sales and administrative costs, inadequate market power to organize efficient delivery of care, and excessive, costly switching between insurance companies. Small businesses with any employees in poor health often cannot purchase insurance at any price.

THE PROPOSAL

For working Americans, the legislation requires all employers to provide at least a basic, low-cost package of health insurance coverage for all full-time workers and their dependents in the same way that they are now required to pay all workers at least a minimum wage. The minimum plan must include protection against catastrophic costs. A system of regional insurers is created to assure the availability of community-rated, low-cost insurance to small businesses, and a subsidy program is established for small businesses facing excessive costs in complying with the mandate. Employers would be required to cover all employees and their dependents, regardless of health status. Employers are assured flexibility to design a plan of their choice, provided that minimum standards are met.

For Americans who are unable to participate in employment-based insurance, the legislation establishes a public Federal-state program that will provide subsidized insurance coverage. Because of the current budget crisis, the public program will be phased in gradually, beginning with the 6 million uninsured, poor Americans who cannot benefit from employment-based coverage. By the year 2000, all Americans will be covered by private or public plans.

IMPACT

--23 million members of working families (two-thirds of all the currently uninsured), including 7.5 million children, will be covered under the private program. Coverage under the first phase of the public program will result in insurance for an additional six million individuals, including 2.1 million children.

--56 million currently insured individuals will gain catastrophic coverage and more than 2 million families that annually experience catastrophic out-of-pocket costs of over $3,000 will be protected.

--7 million currently insured individuals who have health conditions that would make them uninsurable if they lost their current coverage will be able to change jobs without fear of loss of insurance protection.

--Significant reduction in hospital unreimbursed care costs: $5.2 billion.

--Significant savings for smaller firms now providing health insurance: $4.0 billion.

--Selected additional benefits include: coverage for 300,000 disabled children; cost-effective prenatal and well-baby care for 500,000 currently uninsured infants annually.

COST OF BILL

Actuarial Research Corporation(ARC), a respected independent actuarial firm, estimates that the average hourly cost of an indemnity plan meeting the bill's standards is 80 cents for a full-time worker. The employer's share of this cost will be 64 cents. ARC estimates that an employer choosing the managed care options, such as Preferred Provider Organizations(PPOs) and Health Maintenance Organizations(HMOs) can buy a plan at 15 percent less than the indemnity plan cost or about 54 cents per hour, equivalent to a 16 percent increase in the minimum wage. Businesses that currently insure their workers would experience reduced costs, because they would no longer have to pick up the costs of charity care and unreimbursed care for currently uninsured workers.

The total value of the health insurance purchased under the bill is an estimated $33 billion. Offsets for (1) administrative savings for small businesses; (2) potential managed care savings for small businesses; (3) replacement of high-cost, low-value individual policies; and (4) reduction in taxpayer and employer costs for charity care reduce the net cost to $18 billion. CBO has not yet completed its estimate of the cost of the first phase of the public program, but the phasing of the program can be adjusted, if necessary, to meet deficit-reduction targets.

IMPACT ON THE ECONOMY

The legislation will asssure fair competition between businesses that insure their workers and those that do not. It will enhance international competitiveness since the firms that are at the cutting edge of international competitiveness already insure their workers and are paying additional costs to subsidize the health care of workers in firms that do not provide insurance. **Because the legislation increases labor costs, it will reduce employment somewhat, but the effect is minimal. Professor Gerard Adams of the University of Pennsylvania analyzed the proposal using the well-known Wharton Econometric model and found no net effect on employment. The highest estimate of** employment effects came from the Data Resources, Incorporated econometric model, and it found **a minimal increase in the unemployment rate of one-tenth of one percent. The Consumer Price Index** is estimated to increase an average of less than **2/10ths of one percent** over the first three years, with no impact in subsequent years. The legislation will also reduce welfare dependency by removing one of the principal barriers to employment -- the loss of medical insurance.

ADVANTAGES FOR SMALL BUSINESS

Cost savings to firms currently offering coverage

Approximately sixty percent of workers employed in businesses of twenty-five employees or fewer work for firms that already provide health insurance coverage. Small businesses that provide health insurance to their employees face sales and administrative costs averaging twenty-five percent of total premium costs. For firms of ten employees or less, the cost is significantly higher. By contrast, large firms spend only five percent of premiums on sales and administration. By establishing regional contractors as described in the bill, ARC estimates administrative and sales savings in premiums of as much as ten percent compared to similar plans on the current market. In addition, the legislation will make managed care options available to small businesses that could reasonably be assumed to cut costs by an additional fifteen percent. **The result: a potential savings of 25 percent to small businesses.**

All small businesses will have guaranteed access to health insurance coverage without pre-existing condition exclusions through the regional insurer program.

Additional protection for small business

The bill recognizes that the cost of compliance with the legislation may be excessive for a minority of small businesses. Accordingly, the legislation **establishes a subsidy program for small businesses that experience costs in excess of five percent** of gross revenues in providing the required package of benefits. The subsidy will be 75 percent of costs in excess of this standard. Because gross revenues may not be the best measure of affordability in all industries, the Secretary of HHS is asked to conduct a study of the impact of such a standard and establish a different standard, if appropriate, for specific categories of business.

Impact on the American health care system

Basic Health Benefits is not national health insurance. Instead, the legislation maintains the American tradition of a pluralistic health care system and a private-public partnership to assure needed care. The system of private employment-based health insurance coverage for working families is maintained and expanded to all workers. Public coverage is restricted to individuals who are not full-time workers or dependents of workers and the direct provision of such coverage is reserved for States under Federal guidelines. All employment-based coverage is provided by private insurers, under new rules to improve the functioning of the small business health insurance market.

The legislation frees physicians, hospitals, and other health care providers to offer the best, most cost-effective care to all without regard to their ability to pay.

The Basic Health Benefits maintains the best of the current American health care system and assures that its benefits will be extended to all American families.

BASIC HEALTH BENEFITS
SUMMARY OF LEGISLATION

--All employers must provide a minimum package of health insurance benefits to full-time employees and dependents of their employees. A phased-in public program is established to provide coverage to all Americans by the year 2000.

PRIVATE PLAN

Covered Individuals

--Full-time employees required to be covered are defined as individuals normally working more than seventeen and one-half hours per week, consistent with the non-discrimination rules in the tax law. For employees working less than 25 hours per week but more than 17.5 hours per week, the required employer premium contribution is reduced.

Required Benefits

--The package must include medically necessary hospital care, physician care, diagnostic tests, prenatal care, well-baby care, and a limited mental health benefit.

--The package must include catastrophic coverage limiting out-of-pocket costs for covered services to $3,000 per family.

--The package may not contain exclusions from coverage based on health status or pre-existing conditions.

--Deductibles may not exceed $250 per individual and $500 per family except for prenatal and well-baby care, for which no cost-sharing may be imposed.

--Coinsurance may not exceed 20 percent.

--Employers must pay 80 percent of the premium; for low wage workers (under 125 percent of the minimum wage), employers must pay the full premium. A proportional employer contribution is allowed for individuals working less than 25 hours but more than 17.5 hours.

--To promote flexibility in benefit design and to minimize interference with existing employment-based coverage, employers may substitute alternative benefit packages, cost-sharing, and premium shares, as long as the package offered is actuarially equivalent or better than the minimum plan and the basic required benefits are provided.

Special Provisions for Small Employers

--To reduce costs to small employers, the bill establishes a system of regional insurers in each geographical region. Small employers are aggregated into larger insurance units to obtain the benefits of community rating, group purchasing power, and lower administrative costs. Each certified regional insurer must offer a standard set of insurance options and must community rate its offerings. Community rating must be over less than a region-wide basis if necessary to prevent significant interstate subsidies, but it must not be on a less than state-wide basis. If a regional insurer offers managed health care options such as PPO's and HMO's in its regular business, it must also make them available to small businesses through the regional insurer program.

--Small employers who experience excessive costs from complying with the mandate will be eligible for a Federal subsidy. Excessive costs are defined as premiums for an actuarially equivalent minimum plan that exceed five percent of gross revenues. The Secretary is authorized to establish a different but equivalent standard for industries where gross revenues are not an appropriate measure of burden. The subsidy provided will be seventy-five per cent of the excess amount.

-- Small employers with fewer than ten employees who have been in business for less than two years are required to offer only a low cost plan to their workers.

--The bill is phased in over a five year period for very small employers of 5 employees or fewer.

Federal Pre-emption

--To avoid duplicative regulatory burdens and to assure equitable treatment of self-insured and conventionally-insured businesses, the proposal pre-empts state regulation of the content of health insurance. It leaves the states responsible for their traditional role of regulating the financial stability and marketing practices of health insurance companies.

Companion Bill

--A companion bill provides equitable tax treatment of the health insurance costs of self-employed individuals and owner-operators of unincorporated small companies. The bill would allow these individuals to deduct up to 100 percent of their own health insurance premiums from taxable income. Current law allows the deduction of only 25 percent of the premium. To further reduce burdens on employers, the companion legislation simplifies Section 89 non-discrimination rules.

PUBLIC PLAN

--The public program is a Federal-State program that will offer coverage by the year 2000 to all uninsured Americans not covered by employment-based health insurance or by other public insurance.

Phase-in

--The first phase of the public program (implemented simultaneously with the private program) will cover all poor Americans who have no coverage from private, employment-based plans or current public programs (an estimated 7.1 million people).

--The second phase of the program (implemented in 1996) will provide coverage for those between 100 per cent and 185 per cent of the poverty line (an estimated 4.9 million people).

--The third phase of the program (implemented in 1999) will cover the rest of the population (8.8 million people).

--In view of the deficit, the program must be financed within overall deficit-reduction targets. The phase-in can be adjusted, if necessary, consistent with budget needs.

Benefits/Premiums

--The benefits provided will be identical to those required under employment-based plans.

--No co-payments, deductibles, or premiums will be allowed for individuals under 100 percent of the poverty level.

--Co-payments and deductibles for public plan services for individuals under 100 percent of poverty who receive coverage from an employment-based plan will be paid by the public plan upon application by the individual. The public plan will also pick up the employee's share of the premium, if any, for individuals enrolled in employment-based coverage.

--Co-payments, deductibles, and premiums for individuals between 100 and 185 percent of the poverty level could be imposed, at state option. Premiums would be limited to a maximum of three percent of gross income. Deductibles could be set at a maximum of $125 per individual and $250 per family. The out-of-pocket cap would be set at a maximum of one-third of the requirement for private plans. States would have the option of imposing an income-related out-of-pocket cap equal to a maximum of ten percent of income.

--Co-payments and deductibles for individuals above 185 percent of the poverty line would be set at the same levels as for private, employment-based plans. Premiums would be set at the actuarial cost of coverage for all enrollees in the public program.

Payment to Providers

--As in the private program, states must offer payment rates at levels adequate to to assure access.

--Providers would not be allowed to impose additional charges on program enrollees beyond allowed co-payments and deductibles.

Financing and Administration

--The program will be adminstered by states under Federal guidelines.

--The Federal Government will match eligible state expenditures for the program at Medicaid matching rates.

--States must offer managed care and fee-for-service options.

SPECIFICATIONS FOR BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT AS INTRODUCED IN THE 101ST CONGRESS

PRIVATE PROGRAM

I. **INCORPORATES PROVISIONS OF S.1265,** the Minimum Health Benefits for All Workers Act, as reported from the Senate Committee on Labor and Human Resources:

--EMPLOYERS PROVIDE INSURANCE MEETING MINIMUM STANDARDS TO ALL WORKERS AND DEPENDENTS

--MINIMUM PACKAGE INCLUDES:

- physician services
- hospital services
- diagnostic tests
- prenatal/well-baby care
- limited mental health coverage
- catastrophic coverage ($3,000 out-of-pocket limit)

--MAXIMUM DEDUCTIBLES/CO-PAYMENTS:

- $250 deductible/individual
- $500 deductible/family
- 20% co-payment
- no deductibles or co-payments on prenatal/well-baby care

--MAXIMUM EMPLOYEE SHARE OF PREMIUM: 20%

--NO EXCLUSIONS FROM COVERAGE BASED ON HEALTH STATUS

--ACTUARIAL EQUIVALENCY TEST ALLOWS FLEXIBILITY IN BENEFIT DESIGN

--REGIONAL CONTRACTORS PROVIDE COMMUNITY-RATED INSURANCE COVERAGE FOR CURRENTLY UNINSURED AND SMALL BUSINESSES

--ANY INSURER MAY BE CERTIFIED AS A REGIONAL CONTRACTOR IF IT IS WILLING TO MEET THE REQUIREMENTS OF THE ACT

--REGIONAL CONTRACTORS OFFER:

- indemnity and managed care plans
- economies of scale
- minimum and comprehensive coverage

--COMPLEMENTARY LEGISLATION ESTABLISHES TAX DEDUCTIBILITY OF SELF-EMPLOYED HEALTH INSURANCE PREMIUM

II. ADDITIONAL PROVISIONS

--SUBSIDY FOR SMALL BUSINESS FOR WHOM COMPLIANCE IS AN EXCESSIVE BURDEN

- Subsidy provided if cost of minimum plan exceeds 5% of gross revenues
- Subsidy equals 75% of excess cost
- Secretary will establish alternate standard for industries for which gross revenue standard is inappropriate

--PROPORTIONAL CONTRIBUTION FOR PART-TIME WORKERS

- Employers will be allowed to make a proportional contribution for part-time workers working between 17.5 and 25 hours per week
- Workers working less than 25 hours per week may decline coverage

III. COMPLEMENTARY LEGISLATION

- Establishes full tax deductability for self-employed health insurance premium

- Simplifies and reduces "Section 89" non-discrimination rules

PUBLIC PROGRAM

--ALL AMERICANS ASSURED HEALTH INSURANCE COVERAGE BY THE YEAR 2000

--PUBLIC PROGRAM AVAILABLE TO ANY AMERICAN NOT COVERED BY EMPLOYMENT-BASED COVERAGE

--IN RESPONSE TO BUDGET REALITIES, PUBLIC PROGRAM IS PHASED IN

- Phase I (Implemented simultaneously with private program) - Covers all poor Americans with no health insurance (6 million people)

- Phase II - (1996) Covers those between 100 and 185% of the poverty level (4 million people)
- Phase III - (1999) Covers remainder of uninsured population (5 million people)

--BENEFITS/PREMIUMS
- Same package as private plan
- No co-payments, deductibles or premiums for those less than 100% of poverty
- Co-payments, deductibles and premiums related to income for those at 100-185% of poverty
- Those who are above 185% of poverty pay actuarial cost of coverage for public program enrollees

--PAYMENT TO PROVIDERS
- As in private program, states must offer payment rates at levels adequate to assure access

--FINANCING AND ADMINISTRATION
- Program administered by states under Federal guidelines
- Federal match of eligible state expenditures at Medicaid rates
- States must offer managed care and fee-for-service options

ORGANIZATIONS ENDORSING THE CONCEPT OF THE BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT

AIDS Action Council
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Nurse Practitioners
American Academy of Physical Medicine and Rehabilitation
American Airlines
American Agricultural Movement (AIM)
American Association for Counseling and Development
American Association for Marriage and Family Therapy
American Association of University Affiliated Programs for
    Persons with Developmental Disabilities
American College Health Association - Nurses' Section
American College of Emergency Physicians
American Congress of Rehabilitation Medicine
American Diabetes Association
American Ethical Union
AFSME
AFL-CIO
Americans for Indian Opportunity
American Hospital Association
American Jewish Congress
American Medical Students Association
American Nurses' Association
American Osteopathic Hospital Association
American Protestant Health Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Society of Internal Medicine
Association of American Medical Colleges
Association for Children and Adults with Learning Disabilities
Association for Hospital Medical Association
Association for Retarded Citizens of the United States
Association of Schools of Public Health
Baxter-Travenol Laboratories
Black Women's Agenda
Building and Construction Trades Department, AFL-CIO
Catholic Charities
Catholic Health Association of the United States
Center for Women Policy Studies
Child Welfare League
Children's Defense Fund

Church of the Brethren
Church Women United
Citizen Action
City of New York
Columban Fathers Justice and Peace Office
Communications Workers of America
Comprehensive Family Care Center
Consumer Federation of America
Displaced Homemakers Network
Enlisted Association of the National Guard of the United States
Epilepsy Foundation of America
Family Service America
Federally Employed Women
Federation of American Health Systems
Industrial Union Department, AFL-CIO
International Ladies Garment Workers Union
International Union of Bricklayers and Allied Craftsmen
International Union of Operating Engineers
Jesuit Social Ministeries
League of Rural Voters
Lutheran Office for Governmental Affairs, Evangelical Lutheran Church in America
Mental Health Law Project
National Abortion Rights Action League
National Association for Home Care
National Association of Children's Hospitals and Related Institutions
National Association of Commissions for Women
National Association of Community Health Centers
National Association of Counties
National Association of Nurse Practitioner Faculties
National Association of Nurse Practitioners in Reproductive Health
National Association of Private Psychiatric Hospitals
National Association of Protection and Advocacy Systems
National Associations of Public Hospitals
National Assocation of Rehabilitation Facilities
National Association of Social Workers
National Association of Temporary Services
National Caucus and Center on Black Aged, Inc.
National Conference of Gerontological Nurse Practitioners
National Council of Churches
National Council of Community Hospitals
National Council of Community Mental Health Centers
National Council of Jewish Women
National Council of Negro Women
National Education Association
National Farmers Organization

National Farmers Union
National Federation of Societies for Clinical Social Work, Inc.
National Head Injury Foundation
National Health Care Campaign (161 affiliated Health, Civic, and
 Labor organizations)
National Hospice Organization
National Institute of Women of Color
National Insurance Consumers Organization
National Mental Health Association
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Parkinson Foundation, Inc.
National Rehabilitation Association
National Save the Family Farm Coalition
National Union of Hospital and Health Care Workers, 1199
National Women's Law Center
National Women's Party
National Women's Political Caucus
NETWORK: A Catholic Social Justice Lobby
New York City Health and Hospitals Corporation
Older Women's League
Retail, Wholesale and Department Store Union
Service Employees International Union
Teamsters Union
The United Methodist Church / General Board of Church and Society
 Department of Human Welfare
Unitarian Universalist Association of Congregations, Washington
 Office
United Association of Journeymen and Apprentices of the Plumbing
 and Pipe-fitting Industry of the U.S. and Canada
United Auto Workers
United Cerebral Palsy Associations, Inc.
United Federation of Teachers
United Food and Commercial Workers Union
United Mineworkers of America
United Steelworkers of America
Washington Office of the Episcopal Church
Washington Office, Presbyterian Church, U.S.A.
Western Association of Children's Hospitals
Women's Equity Action League
Women's International League for Peace and Freedom
World Institute on Disability

QUESTIONS AND ANSWERS--
THE BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT

1. **Q. IS BHB SIMPLY A BACKDOOR NATIONAL HEALTH INSURANCE PLAN?**

A. No. BHB maintains the American tradition of a pluralistic private-public partnership to provide essential health care. it simply extends that system to the millions of citizens who have been unfairly left out. Two-thirds of the people gaining coverage through BHB will get their health insurance through private employment-based plans.

In fact, BHB is, in large measure, a private alternative to big government. It is intolerable to have thirty-seven million Americans without health insurance, and the government and the taxpayers will ultimately have to step in if the private sector does not do the job.

2. Q. HOW MUCH WILL BHB COST?

A. The respected non-partisan Congressional Budget Office estimates the value of the employment-based insurance purchased as a result of BHB at about $33 billion. The net cost is lower, about $18 billion, because there are savings from a number of sources. These include replacement of high-cost, low value individual coverage ($4.2 billion); coverage of some of the cost of hospital charity care which is now paid by taxpayers and businesses that insure their workers ($5.2 billion); and savings to small businesses from the regional insurer program and the opportunity to participate in cost-effective managed care systems ($4.8 billion). This estimate does not include, because there is insufficient data currently to calculate it, savings from allowing new small businesses to insure their workers under a lower cost plan.

To put these costs in perspective, they represent four tenths of one percent of total wages and fringe benefits and are less than three percent of current national health care costs.

CBO has not yet completed its estimate of the first phase of the public plan. The phasing of the public plan can be adjusted, if necessary, to be consistent with realistic deficit reduction targets.

3. **Q. HOW MUCH WILL IT COST A BUSINESS TO PROVIDE INSURANCE TO ITS WORKERS IF IT HAS NOT PREVIOUSLY COVERED THEM?**

A. The Actuarial Research Corporation estimates the average cost per worker of the minimum package provided as an indemnity plan at $1,619 in 1989, $883 for a single worker and $2,241 for a family plan. Since, in most cases, the employer is only required to pay 80 percent of the cost, the employer's share is generally $1,295 per worker. If an employer chooses to take advantage of a cost effective managed care option such as a PPO or an HMO, the cost would decline another fifteen percent, to $1,100 per year. This works out to about 55 cents per hour for a full-time worker.

4. Q. AREN'T THERE OTHER ESTIMATES PLACING THE COST OF BHB MUCH HIGHER?

A. Any new social program elicits wild estimates of its cost from those opposed to it. Our estimates of the cost of BHB come from the non-partisan Congressional Budget Office, which is relied on by Republicans and Democrats alike. CBO's estimates of the gross cost are partly based on premium estimates by the Actuarial Research Corporation, which is one of the most eminent independent actuarial firms in the country and has been a principal consultant to Administrations of both parties since the Nixon Administration in estimating the value of major new health programs.

5. Q. WHAT ARE THE PROBLEMS WITH SOME OF THE ALTERNATIVE ESTIMATES?

A. Opponents of the bill usually cite three alternative estimates of its cost. One study was commissioned by the Institute for Research on Economics and Taxation and carried out by Gary Robbins, a consultant. Robbins claimed BHB would cost $100 billion, four times as much as the CBO estimate. As CBO pointed out in its testimony before the Labor and Human Resources Committee on November 4, 1987, the Robbins study made four elementary errors. First, it overestimated the premium cost by $12 billion by assuming BHB would cost as much as an "average" employment-based plan. In fact, the benefits required under BHB are significantly less generous than the average employment-based plan provided today.

Second, the study assumed that there would be $45 billion in costs from duplicate coverage of employees in the same family working for different employers. As CBO and Professor Karen Davis also noted in separate analyses of the Robbins study, this estimate ignores the universal insurance company practice of coordination of benefits to avoid duplicate payments for overlapping coverage. These authorities concluded that there would be no additional cost from duplicate coverage, and even the author of the study admitted that any duplicate coverage costs would disappear after a few years.

Third, the study assumed upgrades in existing plans would cost $16.3 billion. CBO pointed out that an estimate like this ignores the actuarial equivalency rules of BHB, which allow employers not to meet many of the specific standards of the minimum plan, as long as their plan is of greater or equal total value. CBO found that the cost of upgrading additional plans would be only $2 billion, an amount included in the CBO estimate.

Finally, the study assumed additional administrative costs of $2 billion. The CBO found these costs to be negligible.

A second study sometimes cited by opponents of BHB is a study by Robert R. Nathan Associates. This study found the cost of BHB to be approximately $10 billion higher than the CBO estimate. CBO and GAO were asked to analyze the accuracy of the methodology used in the Nathan study. Both found the study to have made serious methodological errors that resulted in an excessively high estimate of cost. Specifically, the Nathan study:

--assumed that BHB premium costs would approximate the average costs of current employer-based plans, despite the fact that MHB is significantly less generous than current plans;

--failed to take into account the demographic characteristics of currently uncovered workers which may result in significantly lower average costs for them than covered workers; and

--used an indexing factor to project current costs to 1988 which was too high.

Finally, opponents sometimes cite studies by individual insurance companies or the HIAA in which the BHB benefit package is estimated by a company based on its own book of business. While these estimates are not too dissimilar from the Actuarial Research Corporation estimates, they are sometimes somewhat higher. Gordon Trapnell, President of Actuarial Research, listed the reasons why such estimates tend to be too high at the Labor Committee's November 4 hearing:

--the demographic characteristics of currently uninsured workers make them less costly to cover than currently insured workers; insurance company estimates based on their current book of business do not reflect these differences;

--average costs are reflected in the ARC estimates, rather than the costs of commercial insurance companies; these average costs include costs of Blue Cross plans that get substantial hospital discounts in some areas;

--reduction in the cost-shift from employers who currently offer health insurance to those who do not as the result of the enactment of BHB; these cost-shifts are built into insurance company estimates but would disappear under BHB;

--assumed retention rates for small businesses are higher in current insurance company business than would take place under the regional plan structure of BHB.

6. Q. WON'T BHB REQUIRE EMPLOYERS ALREADY PROVIDING GOOD HEALTH INSURANCE PACKAGE TO UPGRADE THEIR EXISTING PLANS? I HAVE SEEN REPORTS FROM SURVEYS OF EMPLOYERS IN WHICH HIGH PERCENTAGES OF RESPONDING EMPLOYERS SAY THAT THEY WOULD HAVE TO MAKE SIGNIFICANT CHANGES IN THEIR HEALTH PLANS IF BHB IS ENACTED.

A. Most such surveys ignore the provisions of the bill allowing actuarially equivalent plans. Under this provision of the bill, if an employer offers the basic plan benefits and the contribution that he would make to the health plan he offers is as good or better than he would make if he only offered the minimum plan, he is in compliance. For example, if an employer offers a benefit not required under the minimum plan--a drug benefit, for example--he could change some other aspect of the plan, such as raising the deductible. Because of the actuarial equivalency provision of the bill, CBO found only a small cost for upgrading existing plans.

7. Q. WON'T MHB INCREASE UNEMPLOYMENT AND DAMAGE THE AMERICAN ECONOMY?

A. Any increase in labor costs potentially adds to umemployment, but the impact of BHB will be minimal. The cost to an employer of insuring a full-time worker under a managed care option is 55 cents an hour. This is about equal to a 16 percent increase in the minimum wage, and we have had much higher increases in the minimum wage without negative employment impacts. Independent estimates of the economic impact of BHB have been conducted by Professor Karen Davis; the Data Resources, Incorporated, economic model; The Wharton economic model; and CBO. The Davis and Wharton estimates, which take into account offsetting increases in employment in the health care sector, found no net job loss as the result of the bill. The DRI and CBO estimates, which did not take into account offsetting employment gains in health care, found a minimal increase in unemployment of one-tenth of one percent or less over a three year period.

The same public philosophy that says we cannot afford BHB also said that we could not afford Social Security, or Medicare, or unemployment compensation, or the minimum wage, but our society is richer, not poorer, because these programs were enacted.

8. Q. THE UNITED STATES IS STRUGGLING WITH A MOUNTING TRADE DEFICIT AND FACING INCREASING DIFFICULTY IN COMPETING WITH FOREIGN COUNTRIES. WON'T BHB EXACERBATE THIS PROBLEM?

A. No. In fact, BHB will improve the United States' ability to compete in world markets. That is one reason that the Chrysler Corporation, one of the U.S. companies that is facing the stiffest foreign competition, has endorsed BHB. The companies that are at the cutting edge of international competition almost universally insure their workers. In fact, ninety-seven percent of all workers in manufacturing firms are employed by businesses that provide health insurance already. But firms that insure their workers pay too much for that insurance because other companies do not fulfill their social responsibilities. When an uninsured worker is seriously ill and requires hospitalization, he generally gets taken care of. That care is not free; it is paid for by higher charges to other patients and higher insurance premiums for companies that insure their workers.

9. Q. WON'T BHB IMPOSE COSTS THAT SMALL BUSINESSES CANNOT AFFORD?

A. It is important to set the record straight. First, the problem of businesses that do not insure their workers is not unique to small business. In fact, almost a quarter of uninsured employees work for businesses with 1,000 or more employees. Second, the majority of small business employees already work for firms that offer plans -- 60 percent in businesses with 25 or fewer employees. This percentage rises to almost three quarters for firms of under 100 and 80 percent for firms of under 500. Every one of the small businesses that currently insure their workers pays too much for that insurance and faces unfair competition because other businesses do not fulfill this obligation.

Small businesses face special problems in gaining affordable insurance. Sales and administrative costs for small businesses of less than 25 workers average 25 percent, compared to 5 per cent for larger businesses. The mark-up for businesses with fewer than 10 workers is even higher. Because the practice of health screening is virtually universal for very small businesses, some small businesses can not get health insurance at any price or must exclude some workers or the owner of the business from coverage. Current insurance company practices in the small business market guarantee excessive turnover and force companies with even a few unhealthy workers to pay excessive premiums, if coverage is available at all.

In addition, the owner-operator of an unincorporated small business faces discriminatory tax treatment when he purchases insurance. The hired manager of a large corporation does not pay any tax on the share of his premium paid for by his business. The self-employed businessman must pay taxes on all but 25 percent of his premium.

BHB helps all small businessmen who currently insure their workers and lowers prices for those newly required to buy insurance through a system of regional insurers. These regional insurers will offer economies of scale and reduced sales and administrative costs sufficient to cut the price of insurance by 10 percentage points. Under the regional insurer program, economical managed care options such as health maintenance organizations (HMOs) or preferred provider organizations (PPOs) will be readily available to small businesses. These managed care organizations will cut the cost of insurance by an additional 15 percent or more. Small businesses will also have guaranteed availability of coverage at community rates, regardless of the health status of employees and owners.

BHB allows new small businesses of 10 employees or fewer to offer their employees only a low-cost catastrophic plan rather than the full minimum plan in the first two years, when the business is most fragile. Full coverage of the smallest businesses (five employees or fewer) is phased in over a five year period to allow more time for adjustment. In addition, companion legislation to BHB reforms the unfair tax treatment of self-employed businessmen.

A significant new provision of BHB will provide additional protection for small businesses: small businesses who must pay an excessive amount to comply with the requirements of the bill will receive a Federal subsidy to help with those costs. Specifically, small businesses that spend more than five percent of gross revenues in providing the require coverage will receive a subsidy covering 75 percent of the overage. The Secretary of HHS will be authorized to provide an alternate, equivalent standard for industries for which the gross revenue test is not appropriate.

10. Q. MANY FEDERAL PROGRAMS REGULATING BUSINESS PRACTICES EXEMPT SMALL BUSINESSES. WHY DOESN'T BHB HAVE A SMALL BUSINESS EXCLUSION?

A. A small business exclusion would reduce the impact of the bill dramatically and leave far too many workers without health insurance coverage. Forty-eight percent of uncovered workers are employed by businesses with fewer than 25 employees. Thirty-six per cent work for businesses with fewer than ten employees. Twenty-one percent work for businesses with fewer than five employees.

Moreover, excluding small businesses would deny them the benefit of the low cost, community-rated coverage offered by the regional insurers established by the bill. The incentives for risk-skimming, adverse selection, and the continued problem of high rates of enrollment and disenrollment that occur in a voluntary system make participation in the regional insurer program impractical if participation is not mandatory. Thus, a small business exclusion would mean that small businesses would continue to face high costs and lack of guaranteed availability when they purchase health insurance coverage. This not only prevents employees from gaining essential health insurance coverage, it continues the competitive disadvantages small businesses face relative to larger firms.

11. Q. WON'T BHB CREATE A NEW ROUND OF HEALTH CARE COST INFLATION BY INCREASING DEMAND FOR HEALTH CARE SERVICES?

A. No. This point was examined by Professor Karen Davis, by the CBO, and by Professor F. Gerard Adams and they all concluded that the net increase in health care spending generated by BHB was so small relative to the total size of the health care industry and the existing overcapacity in the industry was so great, that no significant increase in inflation rates would result. Indeed, Professor Adams suggested that inflation rates might actually come down because increased volume of services might reduce pressure to raise charges to cover overhead or reach target incomes.

12. Q. CAN'T THE OBJECTIVES OF BHB BE REACHED BY INCENTIVES RATHER THAN A MANDATE?

A. This is an argument often made by those who want to defeat BHB, but even a superficial analysis of the so-called incentives reveals their inadequacy. They generally suggest establishing the tax reform already introduced as a companion measure to BHB and allowing a subsidized buy-in to Medicaid for low-income workers, and argue that these measures plus the growth in multi-employer trusts (METS) will somehow solve the problems faced by small businesses.

The fact is that these proposals are just a smokescreen. Fairer tax treatment for the self-employed is desirable, but a minor incentive at best. Subsidized buy-ins for Medicaid or other public programs are desirable, and they are a feature of BHB. However, covering all the uninsured who are not workers or dependents of workers through public funds will be extremely difficult given the current budget situation. To try to extend such a program to the working uninsured as well would cost approximately three times as much and would be competely impractical. Moreover, such a program would induce the vast majority of employers that currently insure their workers to drop coverage for low income employees and let the taxpayers pick up the cost.

METs can produce some reductions in administrative costs, but not nearly as much as the BHB proposal. METs almost universally apply medical screening, rarely are big enough to have the market power to organize effective systems of managed care, and face continued sales and enrollment/disenrollment costs because they do not function in an environment of required, universal participation. The inadequacy of the MET approach is shown by the fact that, at the same time METs have grown, the number of the uninsured has been increasing at almost a million a year.

13. Q. IS BHB AN UNPRECEDENTED INTERFERENCE WITH THE RIGHT OF THE MARKET TO DETERMINE APPROPRIATE EMPLOYEE COMPENSATION?

A. We require employers to pay a minimum wage, to participate in Social Security and Medicare, to join the unemployment compensation system and to pay to support it, and to pay for workman's compensation insurance. Most Americans would agree that our society is better off as a result of these requirements. In 1988, it is time to require the universal provision of health insurance coverage to all workers.

14. Q. ISN'T IT UNREASONABLE TO REQUIRE FIRMS TO COVER EMPLOYEES WORKING AS FEW AS 17.5 HOURS A WEEK? DOESN'T THIS MAKE IT UNECONOMIC TO HIRE A PART-TIME WORKER EVEN IF THERE IS A GENUINE NEED?

A. The seventeen and one-half hour standard was chosen because it was consistent with the non-discrimination rules included in the Tax Reform Bill and because the sponsors wanted to avoid creating an incentive for employers to reduce workers hours by an hour or two simply to avoid the requirement to provide health insurance coverage. As introduced this year, the legislation responds to this concern by allowing the employer to make a proportional contribution based on hours worked for employees working less than 25 hours per week.

15. **Q. HOW WILL THE PUBLIC PORTION OF BHB BE FINANCED?**

A. BHB will be jointly financed by the Federal and state governments. State expenditures will be matched by the Federal government at the same matching rates used in the Medicaid program.

16. **Q. HOW CAN THE COST OF A LARGE PUBLIC PROGRAM FOR THE UNINSURED BE JUSTIFIED AT A TIME OF GREAT CONCERN ABOUT THE SIZE OF THE FEDERAL DEFICIT?**

A. Any new program increasing Federal spending must be consistent with an overall program to reduce the deficit. The sponsors of this legislation believe that health care for all Americans should be one of Congress's highest priorities--sufficiently high that it should be funded within overall budget constraints. If room cannot be found in the budget to fund the program as introduced, the phasing in of the program can be modified. Regardless of the schedule under which the program is ultimately phased in, however, the time is long overdue for the Congress to make a firm commitment to assuring that the basic human right to health care will ultimately be a reality for all Americans.

17. **Q. HOW WILL IT BE ADMINISTERED?**

A. As in the existing Medicaid program, BHB will be administered by the states subject to Federal law and guidelines.

18. **Q. HOW WILL THE PUBLIC PROGRAM UNDER BHB RELATE TO THE EXISTING MEDICAID PROGRAM?**

A. States will continue to have the option to cover individuals eligible for Medicaid under the Medicaid program rather than BHB.

Nonelderly Population with Selected Sources of Health Insurance by Region, and State, 1986

Region by State	Total	Total Private	Total Employer	Other Private	Total Public	Medicaid	No Health Insurance Coverage
			(in thousands)				
Total	208,023	152,898	136,123	23,828	24,883	16,985	37,027
New England	10,916	8,805	7,939	1,189	990	587	1,333
Maine	953	732	635	118	105	a	145
New Hampshire	883	745	689	99	a	a	101
Vermont	461	359	326	a	a	a	69
Massachusetts	5,085	4,095	3,688	528	513	404	605
Rhode Island	824	700	633	94	83	a	69
Connecticut	2,710	2,173	1,969	350	289	183	345
Middle Atlantic	31,893	24,405	22,071	3,338	3,675	2,982	4,567
New York	15,286	11,052	10,030	1,551	2,008	1,707	2,556
New Jersey	6,682	5,393	4,858	729	585	453	825
Pennsylvania	9,925	7,960	7,183	1,058	1,082	821	1,185
East North Central	36,378	27,956	25,259	3,880	4,488	3,447	5,133
Ohio	9,356	7,153	6,499	939	1,036	838	1,409
Indiana	4,654	3,630	3,258	541	342	182	833
Illinois	10,093	7,606	6,838	1,065	1,333	1,040	1,481
Michigan	8,133	6,199	5,638	860	1,306	1,037	965
Wisconsin	4,143	3,367	3,026	476	470	350	444
West North Central	15,209	11,944	10,000	2,463	1,544	1,166	2,122
Minnesota	3,670	2,931	2,418	636	475	397	389
Iowa	2,532	2,035	1,640	495	280	236	295
Missouri	4,391	3,328	2,941	471	471	340	714
North Dakota	548	443	325	143	a	a	87
South Dakota	595	463	349	138	a	a	103
Nebraska	1,383	1,069	897	239	130	86	234
Kansas	2,090	1,673	1,430	341	188	108	299
South Atlantic	34,639	25,581	22,717	4,050	3,892	2,116	6,393
Delaware	553	421	387	a	a	a	99
Maryland	3,972	3,133	2,869	396	350	211	617
District of Columbia	526	365	329	a	a	a	112
Virginia	4,799	3,808	3,466	473	626	260	622
West Virginia	1,621	1,106	959	189	297	218	295
North Carolina	5,364	3,997	3,574	644	533	295	985
South Carolina	2,840	2,092	1,888	330	406	232	468
Georgia	5,311	3,891	3,519	606	677	431	954
Florida	9,653	6,767	5,725	1,412	1,004	469	2,242

(continued on next page)

Nonelderly Population with Selected Sources of Health Insurance by Region, and State, 1986 (Continued)

Region by State	Total	Total Private	Total Employer	Other Private	Total Public	Medicaid	No Health Insurance Coverage
			(in thousands)				
East South Central	12,973	8,658	7,665	1,526	1,800	1,182	2,950
Kentucky	3,139	2,151	1,895	340	448	304	659
Tennessee	4,010	2,725	2,429	470	620	380	826
Alabama	3,575	2,378	2,144	365	430	294	859
Mississippi	2,249	1,404	1,157	351	303	205	606
West South Central	23,290	15,494	13,827	2,582	2,656	1,542	5,861
Arkansas	2,007	1,312	1,153	246	295	165	487
Louisiana	3,920	2,548	2,234	520	599	416	904
Oklahoma	2,793	1,943	1,690	351	332	153	636
Texas	14,569	9,691	8,751	1,465	1,430	808	3,833
Mountain	11,354	8,351	7,191	1,482	1,085	305	2,242
Montana	715	525	408	153	88	a	134
Idaho	863	626	524	132	a	a	196
Wyoming	441	329	283	a	a	a	78
Colorado	2,769	2,052	1,778	374	384	200	450
New Mexico	1,249	827	670	190	142	a	325
Arizona	2,895	2,129	1,832	394	221	a	651
Utah	1,546	1,181	1,080	139	155	105	253
Nevada	878	682	617	99	95	a	154
Pacific	31,369	21,705	19,454	3,038	4,263	3,022	6,427
Washington	3,808	2,739	2,394	447	656	420	603
Oregon	2,401	1,753	1,573	218	233	167	478
California	23,874	16,217	14,629	2,219	3,270	2,434	5,142
Alaska	453	324	271	a	a	a	97
Hawaii	833	672	587	154	104	a	107

Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.

a - Number is too small to be statistically significant.

THE AMERICAN PEOPLE'S VIEWS ON BASIC HEALTH BENEFITS

CAMBRIDGE REPORTS TRENDS & FORECASTS

Demographic Analysis

Survey date: Q3/88
Sample size: 1445
Variable#: 041

QUESTION:
Please tell me whether you favor or oppose requiring businesses to provide employees who work 17.5 hours a week or more with a minimum amount of health care insurance, as an alternative to government programs.

1. Favor
2. (Don't know)
3. Oppose

		1.	2.	3.
National sample		74	7	19
Total household income	$0-7,999	86	8	6
	8-14,999	76	8	16
	15-24,999	73	6	21
	25-34,999	72	8	20
	35-49,999	73	6	21
	$50,000 and over	65	5	30
Age	18-25	72	13	15
	26-35	75	6	19
	36-45	74	6	21
	46-55	74	4	21
	56-65	76	3	21
	Over 65	74	9	17
Sex	Female	75	7	18
	Male	73	7	19
Race	White	72	7	21
	Black	85	9	6
Education	Some grade school	80	10	10
	Some high school	78	10	13
	High school grad	77	7	16
	Some post-H.S.	71	6	23
	College grad	65	9	27
	Grad. school	73	2	25
Political ideology	Liberal	77	7	–16
	Moderate	73	9	18
	Conservative	73	5	21
Urban/rural	Urban	73	11	16
	Suburban	76	6	18
	Rural	72	5	23
Area	Northeast	71	11	18
	Industrial	73	8	19
	Midlands	74	6	20
	South	81	5	14
	Central	72	5	23
	Pacific	72	9	19

To obtain other demographic analyses or subscription information, please call or write Karen Dwyer at our Cambridge office.

Cambridge Reports, Inc.
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Cambridge, MA 02139
(617) 661-0110

HEALTH CARE PRIORITIES IN 1988

THE PUBLIC'S VIEW

Conducted for:

The Federation of American Health Systems

Prepared by:

The Gallup Organization, Inc.

Poll conducted in January 1988

Employers Should Provide Health Care Insurance

	Yes %	No %	Don't Know %	Total %	Number of Interviews
Total	73	22	5	100	(1014)
Age					
Under 30 years	82	14	3	100	(231)
30-44 years	72	26	2	100	(382)
45-59 years	65	29	6	100	(226)
60 years & over	73	18	10	100	(168)
Education					
Less than H.S. Grad.	84	12	5	100	(130)
H.S. Grad.	76	19	5	100	(367)
College	66	30	4	100	(514)
Annual Household Income					
Less than $20,000	79	17	4	100	(235)
$20,000 - $39,999	75	22	2	100	(366)
$40,000 or more	66	31	4	100	(302)

The CHAIRMAN. Without objection, we will place in the record the opening statement of our colleague, Senator Harkin.

[The prepared opening statement of Senator Harkin follows:]

OPENING STATEMENT OF SENATOR TOM HARKIN

Mr. Chairman, I am pleased that the Committee is here today to consider the important question of how best to provide health coverage for the 37 million Americans currently without health insurance.

The American public supports the notion that we can no longer let this situation persist. In my own state of Iowa, a recent poll shows that 70% of Iowans now believe employers should be required to provide health insurance for their employees.

This is a complicated problem, but certainly an important one which we cannot ignore.

I am pleased to see that the Basic Health Benefits Act includes several provisions to help small businesses provide health benefits for their employees and the dependents of those employees. These include the provision for a phase-in of coverage by very small businesses over a five-year period, an amendment I offered in the last Congress along with my colleagues, Senators Metzenbaum and Mikulski.

I want to reaffirm my committment to the underlying objective of the Basic Health Benefits Act—to assure health insurance coverage for the millions of working Americans and their families who are currently without any coverage. I hope the witnesses today will help us as we proceed toward this important goal.

The CHAIRMAN. Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman.

I am pleased that you have scheduled this hearing to discuss ways to expand access to health care for the 37 million Americans who lack it. We have identified a problem that should be remedied.

However, I have to state that I oppose your particular approach because it will cost billions of dollars, it will force many Americans out of work, it will reduce employees' freedom in selecting specific health care benefits, and will do little to correct the real problems in health care. The most important problem in health care today is rising health care costs, at two to three times the general inflation rate.

Mandated health benefits legislation will be costly to employers and employees alike. While there are no exact numbers regarding who will be covered and at what precise cost in terms of premiums, there has been a range of estimated costs between $1200 and $2600, depending upon individual and family coverage.

Now, I note that your estimate, Mr. Chairman, is $2241 for family coverage and $883 for individual coverage, or $1619 average cost. Since three-quarters of the insured workers earn less than $10,000 a year, they are in the worst condition economically to absorb the cost of an imposed mandate.

This legislation is costly to society. Total projected costs for this new legislation range from $33 billion up to 100 billion additional taxpayer dollars, depending upon the number of employees covered, the cost of the premium, and any changes in existing employer-based health insurance plans to conform with the bill's requirements.

There are some who claim small savings as a result of this legislation. But these savings, of course, are illusory. Mandated health insurance plans cannot be looked on in isolation.

The impact of this bill on American workers must be added to the other mandated benefit legislation being considered in Congress, such as the increases in minimum wage and mandated parental and medical leave. Together, these social entitlements will cause inadvertent harm to employment opportunities and to our Nation's international competitiveness.

Now, I oppose mandating health insurance upon American workers. In opposing S. 768, I do not reject the idea that we should be doing something to increase Americans' access to affordable health care. Employers and employees in American cannot afford our current health care system. The rate of inflation is double-digit, and health insurance premiums alone rose 20 to 70 percent last year.

There are many reasons why these premiums increased. And, the insurance industry attributes most of it to rising costs for health care and administrative claims. We should look at ways of reducing these costs without a Draconian mandate.

Finally, I am very concerned about how American workers will view this mandate. In the last Congress, we enacted the Medicare Catastrophic Care Act of 1988. This law mandates that seniors pay for this new benefit whether they want it or not. I am certain that every member of this committee has heard from seniors in their own State, and they are mad at this new mandate and they want it changed.

I spent much of the last week chatting with seniors in my State, and they are mad. Wait until the American workers get saddled with a mandate.

Now, I offer my colleagues a word of caution. When American workers find that we in Congress have reduced their paychecks, removed their flexibility in determining their own benefits and maybe even put them out of jobs, American workers will join in the ranks of the elderly in opposing Federal mandates to health care.

Before we rush to support this bill, let us find more moderate, rational approaches to improving our health care system. Let us find a solution that does not cost American workers between $33 billion and $100 billion additional per year, that would eliminate between 60,000 to one million jobs, depending upon the estimate, fuel the current inflation and health care costs or deny employees the right to choose the kind of benefits they want themselves in their health care packages.

It is not time for the Federal Government to mandate health care, and for these reasons, I would urge the committee to reject S. 768.

Mr. Chairman, with your permission, I would like to submit for the record a letter from the Coalition on Access to Health Care that will also help to make this record.

[The letter from Coalition on Access to Health Care follows:]

COALITION ON ACCESS TO
HEALTH CARE

April 27, 1989

The Honorable Orrin Hatch
U.S. Senate
Washington, D.C. 20510

Dear Senator Hatch:

The Coalition on Access to Health Care strongly opposes the "Basic Health Benefits for All Americans Act of 1989" (S. 768/H.R. 1845). While the bill sponsors are well intentioned, the legislation fails to respond effectively and realistically to this serious national problem.

We are especially critical that mandatory employer coverage -- the fundamental flaw of S. 1265/H.R. 2508 from the 100th Congress -- has been incorporated again as the cornerstone of this new legislation. By mandating that all employers provide coverage, the bill would:

- Have serious adverse economic impacts on small business;
- Increase unemployment -- particularly for part-time and marginal workers;
- Contribute to rising health care cost inflation; and
- Impose a new federal layer of regulation on employee benefit plans.

The members of our coalition are deeply concerned that millions of Americans lack access to affordable quality health care. And we are committed to finding fiscally and socially responsible means to address this complex problem. Merely shifting costs from government to business, however, is not an acceptable solution. By mandating that employers pay for a government designed and controlled package of health benefits, the Congress would be insulated from public and financial accountability for its legislative action. This would be a fundamental and far reaching public policy mistake.

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Washington, D.C. 20005-2301
202/789-1380
202/789-0776 (FAX)

We believe that government mandated solutions are shortsighted, inflexible responses that will aggravate the problem. The existing pluralistic health care system provides health care coverage to approximately 90 percent of the active workforce. Government mandates and other impediments are counter productive to our highly successful, incentive based system.

Furthermore, we are especially disturbed that effective health care cost containment features are absent from the proposal. At a time when employers are striving to provide broader coverage for their workers, this federal initiative chooses to ignore cost -- the primary problem involved in expanding health insurance.

We are also concerned about the cumulative impact which this bill, and others currently under consideration by the Congress (e.g., minimum wage and family and medical leave) may have on small and large businesses. None of these mandated measures should be considered in isolation.

Our coalition also questions whether the regional insurance structure, as currently conceived and as advertised by the sponsors, is the most effective, competitive approach to providing affordable insurance to small businesses. We also doubt that it will reduce administrative costs. In addition, community rating removes local accountability for health care costs by forcing employers in some areas with more efficient providers to cross-subsidize employers with more expensive providers. It severely compromises any impetus to reduce health care costs in areas where they most need to be reduced, and removes the incentive from wellness and prevention programs that have succeeded in making many Americans healthier.

We also disagree that there will be minimum regulatory burden associated with S. 768/H.R. 1845. Mandated coverage carries with it a serious risk of onerous regulation of insurers and business alike. It contemplates an extensive role for the Department of Health & Human Services in overseeing this program and in promulgating rules and regulations ensuring that employers are in compliance.

The Coalition on Access to Health Care consists of small and large businesses, trade and professional associations, and insurers. Our members stand ready to work with the Congress to fashion a more appropriate approach to the problem.

Sincerely yours,

Sharon Canner
National Association of Manufacturers
Coordinator
202/637-3124

Carole Roberts
The Travelers Companies
Coordinator
202/789-1380

John Satagaj
Small Business Legislative Council
Coordinator
202/639-8500

Aetna Life & Casualty
Alliance of Independent Store Owners and Professionals
American Association of Nurserymen
American Collectors Association, Inc.
American Consulting Engineers Council
American Council of Independent Laboratories
American Council on Education
American Farm Bureau Federation
American Health Care Advisory Association
American Institute of Architects
American Machine Tool Distributors Association
American Road and Transportation Builders Association
American Society of Travel Agents
American Subcontractors Association
American Trucking Associations
Arizona Small Business United
Associated Builders & Contractors
Associated General Contractors of America

Associated Landscape Contractors of America
California Small Business United
Central Reserve Life
Council of Small Business Executives of the Milwaukee
    Chamber of Commerce
Council of Smaller Enterprises
Dallas Chamber of Commerce
Electronics Representatives Association
Employee Benefits Policy Association, Inc.
Florists Transworld Delivery Association
Food Marketing Institute
Health Insurance Association of America
Independent Bakers Association
Independent Business Association of Illinois
Independent Business Association of Wisconsin
Independent Insurance Agents of America
International Communications Industries Association
International Mass Retail Association
Machinery Dealers National Association
Mechanical Contractors Association of America
National-American Wholesaler Grocer's Association
National Association for the Self-Employed
National Association of Brick Distributors
National Association of Casualty & Surety Agents
National Association of Health Underwriters
National Association of Life Companies
National Association of Life Underwriters
National Association of Manufacturers
National Association of Manufacturing Opticians
National Association of Passenger Vessel Owners
National Association of Professional Insurance Agents
National Association of the Remodeling Industry
National Candy Wholesalers Association
National Electrical Contractors Association
National Grocers Association

National Lumber & Building Material Dealers Association
National Moving & Storage Association
National Parking Association
National Restaurant Association
National Retail Merchants Association
National Shoe Retailers
National Small Business United
National Tire Dealers & Retreaders Association
National Tooling & Machining Association
New Jersey Small Business United
Oklahoma Small Business United
Petroleum Marketers Association of America
Printing Industries of America
Professional Insurance Mass-Marketing Association
Self-Insurance Institute of America, Inc.
Small Business Association of Michigan
Small Business Legislative Council
Small Business Profit Center of Greater Denver
   Chamber of Commerce
Smaller Business Association of New England
Smaller Manufacturers Council
Society of American Florists
Society of Professional Benefit Administrators
Specialty Advertising Association International
Springs Industries
Texas Small Business United
The Travelers Companies
USG Corporation
United Bus Owners of America
Western Growers Association

The **Chairman**. Well, we have got a good deal of work to do to convince you to support this. I can tell that right from the outset.

Senator Durenberger.

Senator **Durenberger**. Mr. Chairman, thank you.

My compliments to you for your sustained efforts to secure greater equity for all Americans under this incredibly fragmented system of health care.

Frankly, I am pleased that you did not get it done in the 1970's. I know it probably would have been a less expensive experience if you had, but I really do think the learning lessons of the 1970's and the 1980's have taught us a lot that we needed to know in order to, so-called, do this, do this right.

I share the goal of securing access to the basics of health benefits for all Americans. Since employment is the major route by which most individuals obtain health benefits, the private business sector has to play a role in our efforts to obtain greater parity across various classes of employees.

I was told to be brief this morning, and so I will. And I would just suggest to you, Mr. Chairman, and to my colleague from Utah who I know wants to achieve the same objectives—he just sounds a little negative because this is a very powerful piece of legislation you've got here and it does cost all of the things that he has said it is going to cost—but I think that he as much as you and I and the rest of us wants to see us achieve this goal of universal access.

I would suggest four principles or four things that we are going to have to keep in mind as we reach that goal:

The first is to commit ourselves to universal access. I don't know that we have done that yet. I don't think the last couple of administrations have necessarily done that. And I don't know that this President has done that yet, that everybody in America is going to have relatively equivalent access to health care in this country. And until we all set that as our goal, I don't care where we have these hearings, whether it's this committee, the Finance Committee, or some other place, we are not going to achieve that end.

I bridle just a little bit, Mr. Chairman, when we get compared with South Africa, because the United States has always had national health insurance and we have always had an opportunity for everybody to be covered in this country. It's just that it didn't work very well because there wasn't a hospital or a doctor in this country that would turn people away, for a long, long period of time. And it was only, the way it worked, as you know, is that the folks that didn't have some kind of health insurance, their bills got paid by those that did. And so it was, in effect, national health insurance.

But at some point in time the inefficiencies in that system raised the costs to high that then we started to get this rationing in the system where some people got a lot better care than others and some—and we are going to hear from them today—got none at all.

So, it isn't quite fair, I suppose, to say that we and South Africa fall in quite the same boat, because that is not fair, I don't think, to America. That doesn't say we don't have a problem.

The second principle is employment as access. And again, I think this is a conclusion as a Nation we need to come to because practically all Americans depend on earnings for the purchase of health care, and it is the obligation of public policy to expand the opportunity to all employed persons.

I would suggest we are going to have to do that by changing the current tax treatment of employer-provided health benefits to eliminate the substantial tax preferences for large employers, for those employers who can readily pass the costs on in the price of their goods and services, and the bias in favor of higher-paid employees which currently exists in the subsidy.

The third principle is social insurance is access. And I know we are the Labor and Human Resources Committee and we don't have jurisdiction over it and your bill is not drawn to include the Social Security Act.

But for those people who are retired, disabled, unemployed, or whose earnings levels are low, the Social Security Act and the social insurance system in this country can and must be reformed to supplement earnings in order to make premium payments for health benefits.

The fourth point, accelerate reform of provider payments, utilization, and quality standards. This Nation will never have the financial capacity to provide its citizens with universal access to basic health care, including long-term care, unless we move quickly to deal with our failures to measure quality and to remedy the inequities in provider payments and, I would add, the overutilization that abounds in the system.

As the vice chair of the Bipartisan Commission on Comprehensive Health Care, I stand ready to assist in producing either necessary modifications to this proposal or alternative legislative solutions that can gain widespread support. It is as unacceptable to me as a Republican, Mr. Chairman, as it is to you as a Democrat that a wealthy, productive, compassionate America should continue to fail to provide basic health benefits to all of its citizens.

The **Chairman**. Thank you very much, Senator Durenberger, for your very constructive comments.

Senator Kassebaum, do you have comments?

Senator **Kassebaum**. Thank you, Mr. Chairman. I will wait until the witnesses testify.

Senator **Hatch**. Mr. Chairman, could I make one other comment? Mr. Chairman, I apologize to our witnesses. I want to welcome both these distinguished initial witnesses here, my good friend Elliott Richardson; and of course Deborah Steelman, who I think knows as much about domestic policy as anybody in this city today.

But I have to go to a memorial service, so I have to be excused. And I hope that you will—and please do not take it that I am not totally interested in this, because I really am. I think this involves some very important issues, and I compliment the chairman for raising them. I cannot support this bill in its present form but I do want to come up with a way of solving these problems for these 37 million Americans who do not have adequate health care at this particular time, or even access to health care.

So, we are interested in what every witness says today, and I welcome all the other witnesses as well, of course.

So, if you will forgive me, Mr. Chairman, I do have to be excused.

The **Chairman**. All right.

We have as our first panel Elliott Richardson and Debbie Steelman. We want to welcome Elliott Richardson back to this committee. He had the opportunity to testify before our committee on a number of different health policy issues as well as appear before numerous other committees as he wore a variety of different hats in President Nixon's administration, and he has held more Cabinet positions than any other American, I believe, in the history of our country.

He has always taken a special interest in health care and was extremely constructive and positive in helping in shaping and fashioning the health policy issues under President Nixon.

Then we will hear from Debbie Steelman, who is a health lawyer at Epstein, Becker & Green, and been a program associate director with the Office of Management and Budget, and was domestic issues director for President Bush.

Ms. Steelman, we look forward to hearing your views, too.

Both of these witnesses are on a tight time frame, so we will start off with Secretary Richardson. I know that he has to leave here by half past the hour. So, we will do the best we can.

I know you are under pressures, too, but we will hear from Secretary Richardson.

We want to welcome you. It is good to see you, Mr. Secretary. Secretary Elliott Richardson, you just got back from overseas only, it appears, I am sure, to you, only a few hours ago, even though it was a couple of days ago. We know you made a very special effort to be here, and we are very grateful to you.

STATEMENT OF ELLIOTT RICHARDSON, ATTORNEY, MILBANK, TWEED, HADLEY AND McCLOY; FORMER SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, WASHINGTON, DC, ACCOMPANIED BY DEBORAH STEELMAN, HEALTH LAWYER, EPSTEIN, BECKER & GREEN, WASHINGTON, DC

Mr. RICHARDSON. Thank you very much, Mr. Chairman.

Members of the committee, I am reminded of the Yogi Berra phrase, "Deja vu all over again." I was just looking this morning at my testimony of 1971 on this subject, and it is curious to note how many similarities there are both in the exposition I then gave to this committee of the need for assuring better access to health care and the measures to accomplish this that we proposed then.

We said then that the time for action is long overdue, and that was nearly 20 years ago. We pointed then to the very large number of individuals who lacked insurance, but the situation clearly is worse now, first, because that number has grown from 27 million to 37 million, and because in those days the trend line was toward the expansion of private health insurance coverage whereas now the trend line is flat or down.

It was quite clear to us in those days that access could be made essentially universal on an equitable basis by only one of two routes. The first choice would have been to move toward a European or a Canadian-style health insurance model. And I seem to recall, Mr. Chairman, that you were the sponsor at that time of a proposal somewhat along those lines. We in the Nixon Administration came forward with a conservative approach, an alternative——

The **Chairman**. I would buy it today. [Laughter.]

Mr. **Richardson** [continuing]. That we regarded as predicated on greater reliance on private health insurance and embodying elements of pluralism. It happens the choice we pursued then is one that I am glad to note you have been persuaded of in the meantime.

Looking at a comparison between the basic health benefits bill and our 1970 version, it is noteworthy that there are few, if any, significant differences allowing for adjustment of dollar amounts as a consequence of the depreciation of the dollar's purchasing power in the meantime.

Each bill required employers to provide a basic package of health insurance coverage, including catastrophic coverage, for employees and their families. For the minority of the uninsured that had no connection to the workplace, Medicaid was to be expanded and improved. Thus, by a combination of public programs and employment-based coverage, all Americans were assured health insurance and access to health care.

The basic health benefits bill follows the pluralistic model that our Republican administration proposed in the 1970's, as I have already noted.

Your proposal combines an employer mandate to provide coverage with a public program for those who are not members of working families. Like our bills, your legislation requires employers to provide a basic benefit consistent with what most employers already provide rather than a "Cadillac" plan and allows flexibility in plan design.

Like our bills, your program recognizes the private health insurance market must be improved and reorganized in order to make it work well for small employers. Like our bills, your program—I refer, incidentally, to "bills" because the one I testified for in 1971 was introduced for the administration by Senator Wallace Bennett; it was the Federal health insurance plan. It was revised somewhat and reintroduced in 1974. It was called then the Comprehensive Health Insurance Plan, or CHIP.

In any case, like those bills, the basic health benefits bill recognizes that the private health insurance market must be improved and reorganized to make it work well for small employers, and like those bills, the basic health benefits bill provides subsidies for small employers that might be particularly hard hit by new a requirement to provide health insurance.

The fact is, of course, that once you decide that you are going to solve the problem of the uninsured by a combination of a private mandate and a public program expansion, the logic of the problem inevitably leads you to a common program design.

I am reminded, incidentally, Mr. Chairman, that in connection with a number of issues as to which I used to have to testify in those days, I would say that this is the best idea we have been able to come up with. We have tried to make it as economical and efficient in achieving its objectives as we know how, but that doesn't mean that it can't be improved.

It is in the form it is because the problem is the problem that has the characteristics that the problem has and the outcome we propose was an outcome determined by the elements of that problem on the one side and the desire on the other that is suggested to retain the elements of pluralism, reliance on private insurance, employer responsibility, and so on.

In conclusion, Mr. Chairman, I would just add that I am convinced that the vast majority of the American people regardless of ideology or party share a common belief that health care should be a basic human right, indeed that it is a basic human right, that it is fundamentally unfair that there should be very large numbers of people who either are denied access to health care or whose health care is lacking in the qualitative standards available to those who can better afford it.

The solution you have proposed is essentially a moderate, pragmatic, nonpartisan approach to the needs of million of Americans who have been unfairly denied the health care that all of want and expect for ourselves and our families. I think the time has come, Mr. Chairman, when we should seek to complete the work undertaken almost two decades ago.

Thank you, Mr. Chairman. I would be glad to respond to questions if I can to any questions that you or the committee may have.

The CHAIRMAN. Thank you.

Ms. Steelman, with your indulgence, we might just have a brief question and then we will move on and I will excuse the witness.

Let me ask you, Mr. Richardson, how you reach this public and private balance and how you respond to the allegation or charge that this kind of a burden on the private sector is going to be so devastating that it is really going to be counterproductive in terms of achieving the objectives, because of the disruption in terms of the total numbers of people who are employed, the burden that it is going to place on the private sector?

Mr. RICHARDSON. I would have three responses briefly, Mr. Chairman. First, if access to decent health care is a basic right, it is important then that something be done about it and the question of cost is a question that has to be addressed but cannot become the barrier to the fulfillment of the responsibility to meet that right.

Second, the primary impact of the legislation is to require all employers to do what most employers already do. The problem of cost arises with respect to small employers and to people who are, as individuals, unemployed or otherwise not covered at all.

As to the latter group, in the case of the small employers, you could mandate the same coverage without any form of public cost. The result would be to increase their costs and require them to be passed on to their customers or people who employ their services.

The question of subsidy is a question one reaches at this point only in order to mitigate or reduce that burden. As to the remainder, those not covered at all, we of course long since have addressed the public responsibility for some response to that problem through Medicaid.

To the extent that people in that group can be picked up through some form of coverage as an adjunct to this approach, it reduces the element of reliance on what is essentially a welfare or a means-tested program.

This last, of course, is the toughest part of working out such an approach. I would note that, speaking of what I said earlier about the elements of the problem on the one side and the limited options available for dealing with it, that the National Leadership Commission on Health Care has come up with a quite similar approach. It differs in detail in addressing this last tough set of problems. But I think that the costs, given phasing and so on, ought to be manageable and ought to be borne.

The **CHAIRMAN**. Your reaction to the approach that relies strictly on the expansion of public programs like Medicaid, that is usually presented with the statement that mandating a health program is excessive interference in the private sector and therefore we ought to expand instead through a public program like Medicaid.

What is your response to that?

Mr. **RICHARDSON**. My response to that, Mr. Chairman, is that we ought, so far as possible, to rely on a program that can legitimately be characterized as insurance. Speaking of conservatism, my basic philosophy on this subject comes from Marion Folsom, who was my boss in the Eisenhower Administration when we were addressing some of these very same problems.

And he taught me that insofar as it is possible for an individual receiving the benefits, whether income benefits, health insurance, or any other form of social insurance, that it is important to maintain the sense of dignity, that these benefits are being received as a matter of right rather than to have them characterized as welfare and made available essentially as public charity.

And while it is hard to avoid some element of subsidy in a health insurance program just as it has been impossible to avoid an element of subsidy for people at the lower end of the scale in social security income benefits, nevertheless the feeling of dignity for the individual recipient is vastly different in the case of an insurance program and a welfare program, and Medicaid is welfare.

The **CHAIRMAN**. I suppose you realize we have about four million Americans who today are in poverty but have some kind of employment based health insurance coverage. I imagine if you were in the private sector and a businessman, and we were moving into a public sector program for the poor, there would be a pretty good expectation that those businessmen who are today providing some health insurance would drop theirs and let the taxpayers pick it up.

Would that seem logical to you?

Mr. **RICHARDSON**. I think that is quite possible. They would obviously have an incentive to have the costs spread as broadly as possible, and the broadest way of doing that is through the tax system.

To the extent that you had some element of subsidies for small employers and, of course, for the unemployed, you would have that element to some degree in any case.

I think that this should be viewed as a matter with the principle of pluralism, reliance on private insurance, the sense of dignity attached to participation in an insurance program first and with a recognition that the costs are going to be spread in any case.

One of the consequences, I am sure this committee knows better than I, of the failure to address the problem of inadequate coverage is cost shifting from the care of the poor, medically indigent, to private health insurance programs now. The result is that the people who are paying insurance premiums are paying more because there is not either mandated coverage for the remainder or adequate subsidy.

So, one could well argue that the net effect of this would be to reduce the premiums for the general public, including especially the very large employers who already have more than adequate health insurance packages for their employees.

I would think, for example, that the automobile industry would like this bill for that reason.

The CHAIRMAN. Senator Kassebaum.

Senator KASSEBAUM. Thank you, Mr. Chairman.

One, I just very much have enjoyed and respect hearing some thoughts of one who was involved in the early 1970's in trying to look at this same issue, and I think it helps us to see where we go now.

Obviously, the same concerns that you had then we have today. How to strike a fair balance and address the numbers of people who are not having the opportunity to benefit from health insurance is still going to be one of the trade-offs that we will have to analyze. They are much the same as you have mentioned in support of the legislation.

Thank you.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Before you came in or as you were coming in, I was remarking that I thought that universal access is an essential and I also thought that the employment sector is the place we ought to concentrate on. And I sure don't disagree with the author and the chairman of this committee on either of these two issues.

Then I indicated that social insurance reform is probably a very critical part of this because we are not just talking about acute care, we are going to be talking about long-term care and a lot of those other issues as well.

So, I really—and I would just like your advice on this—I don't know how we get to meeting the goals of universal access using the workplace, in part, to do that unless we also go into the Social Security Act and we do something about the current Titles 18 and 19, in particular, I suppose, to make them work better in supplementing premiums costs.

Do you disagree with that at all?

Mr. RICHARDSON. No, I don't disagree with that.

I think, of course, one cannot overemphasize the extent to which one is dealing in this context with systemic problems, and you really cannot intervene at one point without addressing the others. The problem of access is closely linked to the problem of utilization, of quality, of cost containment, and optimally one would seek to address each of these issues across the whole front lest by intervening in one place the result is to create a distorted impact.

And I think clearly there has to be considered in an approach of this sort how it meshes with Medicaid and Medicare. And optimally it ought to reduce reliance on these. But as you say, it's important obviously to look at the problem in as broad a context as possible.

Senator **Durenberger**. Did I understand one of your responses to the chairman's question that you also think the current tax subsidy for employment-based insurance could undertake some change and some reform?

Mr. **Richardson**. I don't feel really competent on that question. But so far as I understand it, the answer is yes.

Senator **Durenberger**. Thank you, Mr. Chairman.

The **Chairman**. I would certainly read the way that particularly the tax system treats the smaller businesses, treat them differently than the larger businesses, as unfair and I think this has been something that we have recognized and we would want to adjust.

All right. Well, I want to thank you very much, Mr. Richardson, for coming up here and reminding us about the long time we have been addressing these issues and questions, and we recognize that among the American people I think this issue is back.

You referred to the bipartisan presidential panel of President Ford and President Carter. Their report was out just several weeks ago, and we have the New England Journal of Medicine that has pointed out that this is a time to address this issue. We have had the opportunity to serve with Senator Durenberger on the bipartisan joint panel between the House and the Senate to consider both this issue and the long-term care issue, and we are supposed to report later this year.

And I think the point that you made in your statement about where the flow line in the early 1970's where the insurance and employment, at least there was movement there for those that were working to get some kind of coverage. And that has really reversed, as we look at the Department of Labor's own studies now about the new jobs that are coming on, and these are disproportionately coming in the sectors that are least likely to cover their workers.

So, it really is a time, I think, to address this issue, and we thank you for making a special effort to come here and give us the benefit of the good deal of thought that you have given to this issue.

Thank you very much.

Mr. **Richardson**. You are very welcome. It is a pleasure to be back here. I haven't testified on this subject matter for quite a while. But once having become involved and concerned, it is impossible ever to wholly walk away from that kind of concern.

The **Chairman**. Well, it has been very helpful to us to have your thoughts, and I am sure as this whole debate goes on, we will be asking your counsel as well as we move through this legislative process.

We thank you very much for joining us.

Ms. Steelman, we welcome your testimony and we thank you very much.

Ms. **Steelman**. Thank you very much, Senator Kennedy.

I have submitted testimony for the record, but I will just go through a few points this morning.

Number one, I would really like to indicate how much I admire your leadership on this issue. It goes without saying that without leadership this issue would not be on the public policy agenda today.

I would also like to say that I think there is no question we all agree on the central point here, that access in a rich country like ours should be an issue without contest. The question is how we get there. And again I would like to congratulate you on your legislation, S. 768. It is a far better bill than last year's, but the changes that have been made seem to me to underscore the key problems that remain from the prior legislation.

I would like to talk just a little bit about S. 768, a little bit about some alternatives that might be more productive, and then some of the broader questions I think we need to address.

Clearly, I don't think mandates is the way to go, and I don't think we have realized this only since 1971. Compulsory health insurance has been proposed and rejected roundly about every 20 years since the turn of the century; 1911, to be precise.

We have got to come to grips with some of the basic fundamentals about our country, how we like to buy insurance, how we like our public programs, what we expect from our Government, from our employers, and from ourselves. Mandates, mandated health benefits at least, seem to violate some of these key concepts.

Number one, let's just talk about the population we are dealing with. It is a very heterogeneous population. It is a very complicated population. But clearly, most of all they are poor. They are half below the poverty line—excuse me, one-third below the poverty line, two-thirds above it. But I think the most important thing I could say is that three-quarters of these workers who are uninsured earn less than $10,000 a year. That is $192 a week.

That kind of money, even if they had to pay a 20 percent cost share and a $250 deductible, they would easily end up spending more than four percent of their income on health insurance.

I don't think as our country looks at itself and access to health care that this is the kind of burden we want to levy on these people.

I would also like to indicate that the employers who have these low-income people in their jobs are also at the low end of the income spectrum. They are very generally in the retail and service sector. Two-thirds of the bankruptcies are in this sector. Two-thirds of those bankruptcies are in small firms.

Clearly, mandates offer a benefit that is illusory. It really doesn't help the problem for low income, and it certainly burdens low-income employers much more so than their counterparts who, of course, are already offering health insurance.

Let me say again I don't think this really has much to do with conservative or liberal values. It really is a question of effectiveness: how can we create legislation that pulls together the private sector, the employee, the beneficiary, and the Government to make some sense out of this helter-skelter scheme we've got today?

A few points specifically about the bill. Number one, I find I am somewhat skeptical about the public program being phased in to meet the mandates. Clearly, we have not had increases in the Medicaid program in over a decade. We have not had any big increases in any domestic program in over a decade.

To accomplish the goals stated in this legislation and to do really what we need to do in Medicaid, I think we would agree will cost Federal and State Government about $10 billion to $12 billion. To indicate today that that kind of a change is going to occur I think is simply not supported by the evidence. This budget agreement does not include anything like that. In fact, there has been great fanfare over a measly little $500 million increase in Medicaid. And if we are looking at the next decade, I don't see any way in terms of something less than real structural reform to get that kind of money.

So, what I see as a mandated benefit program because it doesn't have a budget impact much more likely to be legislated, much more likely to be enacted than a program that does have a budget impact.

Consequently, the deductibles, the premiums, the co-pays, the changes that you have made in this legislation to help the low income are somewhat unlikely. So, I would like to suggest a little bit later some ways that perhaps we could help those populations without creating those barriers to care, granted at some cost to the Federal Government but not as much as the kind of changes that you have recommended.

Second—and I think this is something that others later and I am sure before me have said—there is a significant problem with the lack of cost containment focus in this bill. Health care is not offered by many employers because they cannot afford to offer it. Simply requiring them to do so does not change that burden, it simply changes the dynamics, the economics of their business, which would most likely result in disemployment.

Regarding the things that you have done that, hopefully, would have some changes for the cost of these proposals, regional pools is the one that stands out. And I would like to say that there is really no proof that regional pools in and of themselves bring costs down. The only proof, really, is that they will force cross-subsidies between States or between risk pools that will allow people who have affordable health care today to see their costs go up.

I think mandates would also hinder our ability to take advantage of local differences, provider discounts, cheaper benefit packages, and various State initiatives. And there is no question that some insured would lose better benefit packages. This is in fact part of your cost estimate, that we would recapture tax expenditures through dropped benefits.

With regard to the public program, I would just like to say a couple of things. Number one, I question the fiscal capacity of this Government a mere 11 years from now to meet the obligations to the immense population you are suggesting, when today we cannot even meet our obligations to the poor.

I would like to apologize for my voice. I am getting over some weekend flu here.

Let me go on and say perhaps some of the things we could do that might make some sense. Now, these things, unfortunately, are very complicated and they are not as easy to sell perhaps because they require a tremendous understanding of the interactions of Government and insurance. And I cannot begin to explain to the extent I would like to exactly how these would work. But we think they would have a better chance of working, of fixing the problem, and a better chance of costing the Government and employers less.

Number one, one of the main problems we have in terms of a barrier to insurance—somewhere around ten million people do not have insurance today because of this—are various State mandates. If we could have an ERISA preemption, which I recognize is in your legislation and which I support, we could have insurers offer lower-cost core benefit prototype plans. These would be designed specifically not to compete with the kind of Medicaid benefits that this population can achieve. So that we would be trying to create a program that looks like this instead of one that looks like this [demonstrating].

For uninsurable employer groups, a private reinsurance mechanism to take those high-cost claims out of the pool so that we could have more affordable coverage.

For uninsured individuals, risk pools. HHS should have the authority to establish pools in States which fail to do so themselves.

Those are three simple things that could be done—and there are others such as the 100 percent deduction for small employers, a fairly costly proposal—that could be done to the private market to expand its reach into these lower-income populations.

What could we do about Medicaid? Well, clearly we need to increase Medicaid up to the poverty line so that people who fall below the poverty line regardless of disability, income ranges, or sex, could have access to this program. That is an extremely expensive proposition, as I don't have to tell the members here.

So, what can we do while we're building toward that that would try to make Medicaid expansions very targeted, very effective, work toward the population in a way that they can afford it? One way is a buy-in to enable the near-poor and the poor who do not meet current categorical eligibility requirements, to pay income-related premiums for a limited set of Medicaid services. These would be limited to hospitals primary, preventive, and ambulatory services, again so we would have a program that looks like this [demonstrating], that is interwoven.

We cannot afford to give the full benefit package to all people under the poverty line today. So, what we should do is make sure that all people under the poverty line have access to care, preventive care, so that they will seek out doctors, they will get services, they will have the immunizations. This kind of service would in fact be barred by your $250 deductible in S. 768.

Another thing we could do is have a Medicaid spend-down similar to the concept that we used to do on long-term care, so when people do have catastrophic expenses and spend down they can have Medicaid services for hospitals and other necessary care. This is a better way of addressing the issue than the $3000 catastrophic limit you have suggested in S. 768, which of course is beyond the means of most of this population.

Additionally, we could have a Medicaid buyout which would allow State Medicaid programs to take advantage of employer-sponsored coverage for low-income workers and allow Medicaid to buy that premium. Where this is done in some States today, States have recorded savings, and I would certainly invite later witnesses to comment more about that.

Lastly, of course, we have to do something significant in this country regarding the explosion of health care costs. Now, again this is nothing new. We have had double-digit inflation in health care for decades. That does not mean that we can ignore it in passing on more building blocks that build on the same mistakes that have resulted in this double-digit inflation for decades.

We have to build into the system better incentives for health care: case management, outcomes research and effectiveness measures. We have to deliver more appropriate care and have a research base that funds this. Those things go without saying, except that they are not in your bill.

Overall then this legislation costs about $40 billion to the private and the public sectors, the smallest part, of course, in the public sector, but does not really have, at least in the next several years, a real possibility of being enacted all at once. Therefore, you have to look at what is most likely to be enacted. And what is most likely to be enacted will not be of help to low-income Americans.

The proposals that I have gone through, which would cost somewhere between $8 billion and $9 billion—granted, they are Federal dollars—could cover about 20 million people, but they would be the most needy people as opposed to those cared for by the enactable provisions of S. 768.

Still, I admit this is a number that is very unlikely to have support in near-term budget agreement. So, what do we do? Well, obviously, as we strive to carve out these bits and pieces, I think we stand the danger of getting lost in the forest for the trees.

I look forward to the commission's work, Senator Durenberger and Senator Kennedy, to ask some of the more fundamental questions that need to be asked about access to care because I think probably the worst thing I could say about S. 768 is it builds on the current building blocks, those buildings blocks are no longer appropriate.

We have to face facts to a couple of things in health care. Number one, we are going to spend a heck of a lot more in health care over the next two or three or four decades. Our demographics, both the aging and the poverty population, far outbalance our capacity or anything we can control in terms of cost constraint mechanisms. We are going to spend a lot more.

The real question then is how do we care for the poor and how do we equitably spread the burden of the costs between our employers, our citizens, and our Government? Certainly Senator Durenberger's opening comments have taken us a little bit toward the right direction of those questions, but I would ask some that are very fundamental:

Number one, we have got to face up to the acute needs of our poverty population—period. We have got to fix Medicaid, and that is about $10 billion to $12 billion. If we cannot reach a national consensus on a tax increase to support that, then we have to look for other ways, and one clear and easy way is to get long-term care out of Medicaid and write a State maintenance-of-effort requirement. That would free about $11 billion that could be redirected toward acute care needs of the poverty population.

Then we have to take a look at Medicare. We have to say is it appropriate to have a program that is designed along provider settings rather than one that is designed to insure against financial risk.

We have to take a look at the disabled: is it appropriate to require the disabled and those in need of long-term care to rely only on Medicaid as their real only options?

And tax policy: how can we continue to tax tobacco and alcohol less than they cost us in health care?

These, and a number of other questions, I recognize are outside the jurisdiction of this committee, but in any form in which health care is discussed I hope these two committees can work together very well and very closely because there is no other way to solve the real problem. As I said, compulsory health insurance has been proposed and defeated about every 20 years since the turn of the century. We have always been frustrated with double-digit increases in health costs.

The question is how do we accomplish an effective program, recognizing our budget issue, recognizing the complexity of health care itself, recognizing the unassailable right to health care in a rich country such as ours?

I believe the only thing we can do is radically reform our current health care financing structure, starting from ground up. Some of the proposals that are in S. 768 would be a necessary part of that restructuring, but they are not enough. Employers have done a far better job in addressing these issues and those issues within their control than has Government. I don't think it is any question that we can blame them for crying to Government to do better.

But for us to do better, I think we have to start over. We have to look quite radically at health care financing. And I have to say that mandated benefits really isn't a radical idea. It is a rather outdated one that has been defeated before and I hope would be defeated again and in its place would rise, through your leadership and that of others, a program that can really address the needs not only of our poverty population but of our employers and our citizens and our Government to better balance and plan for the health care needs of our next 20 to 30 years.

Thank you very much.

The CHAIRMAN. Thank you. Thank you very much. We appreciate your testimony. You have obviously spent a good deal of time on these issues.

We are always mindful of the fact that we haven't been able to get national health insurance, and we are reminded that when we were in the early part of the debate, it was charged that the proposal was too large a program, we were trying to do too much. Now we are at a point in the debate where we have spread it over so long a period of time, that people charge we are not really coming to grips with those that are in the greatest need. So, you sort of get whipsawed on some of these matters.

Since that time, we are already up to, what, $460 billion this year? What are we, 11.4 percent of our GNP with no coverage for long-term care and home health care we are not even addressing?

So, Lord only knows we are spending the money. And the fact that I think we have got many—I know that you and I differ on this—the fact that we do have these explosions in terms of health care costs and that is because we have not been able to rationalize our whole health policy.

I agree with you, we have to deal with the problems of inflation in the health industry, but I for one refuse to say that we are going to hold the uninsured and the poor people hostage until we put an effective system in place.

You say, well, we've got this problem and you're just going to add more to it. Well, the question is why these people ought to be held hostage or blamed because we are not coming to grips with the issue itself.

So, I think we are interested in trying to find ways in which we can address the 24 million who are employed and do not have coverage, and facing the realities which you point up quite clearly that there aren't the resources for the Federal Government due to address these people, and those that are living in poverty and are not injured.

You criticize the mandate portion of our plan for setting co-pays and the deductibles that costs are too high for poor employees to pay. Are you aware that less than one-quarter of the working uninsured are poor?

Ms. **Steelman**. Three-quarters of the working uninsured are in families with less than $10,000. I don't call that wealthy in this country.

The **Chairman**. No, it's not. But if you are going to find the numbers of those people who, even a limited number—guess we have figures of about four million, 3.7 million, who are poor and have employment-based insurance, and you are focusing on dealing not with a mandated program but with a public program to address those that are poor, what incentives will there be for an employer to continue even that coverage? What protection is there going to be for the taxpayers that they are not going to get dumped on the public roll?

Ms. **Steelman**. The public and the private programs are designed to complement rather than compete. The same benefit package would be offered in the private program as in the public program.

The functions of the private program, particularly for the low income, would be to design a preventive package to be available, hopefully, for somewhere around $50 to $60 a month, be subsidized by the State on an income-related basis, that would offer preventive care so that they do not run up against this barrier to care that would be posed by your $250 deductible. They could get preventive services. Then, that is a Medicaid structure.

The private plan would be formed much along the lines of what you are suggesting, a higher deductible and higher catastrophic limit. But with this interaction between the public and private program, you wouldn't run up against that obstacle of the $250 deductible.

Many people who offer plans in this area right now to the low-income population have already indicated time and time again that that kind of a deductible really does bar people from seeking the kind of preventive care they need.

So, what we try to do in my two elements is do a teeter-totter, so on the one side Medicaid can offer a stripped-down benefit package that will allow them access to preventive care and on the other hand offer a package that businesses can afford because it would have higher deductibles.

The CHAIRMAN. Well, that approach is certainly what we are proposing. In terms of the $250, I have never been convinced about the overutilization. The basic overutilization, we have found that basically among the more affluent people in society. So we can address the $250 or the size of that deductible.

But as you are concerned about the costs, it would certainly—and you make that point, and all of us are mindful of it and that is why we have tried to have a phased-in program on this; we understand that—but on the other hand, just targeting the public aspect of it when you have many of those that fall within that poverty characterization and that are getting at least some coverage today, it just seems to me you are inviting the public to pick up more than what is even happening at the present time.

Ms. STEELMAN. Excuse me.

The CHAIRMAN. Yes?

Ms. STEELMAN. The public program that I have outlined is much smaller and much narrower than current law. We would leave current law in place until such time we could afford to eliminate the categorical requirements under the poverty line, and we would allow people to buy this stripped-down preventive care package up to the poverty line, which we could do, hopefully, at a cost of about $2 billion to $4 billion rather than the full-blown Medicaid expansions of everybody under the poverty line costing somewhere upwards of ten.

In terms of the public program substituting for private coverage, I think that is far more likely under S. 768, in which the phase-ins that go up over the next 11 years go far beyond the poverty population and would truly serve as an invitation to invite public substitution for current private coverage.

The CHAIRMAN. Well, I would be glad to go over those figures, and will. We both agree on a program that is going to provide essential services, and you say ours costs 11 and yours costs two to four. I don't know. I certainly want to get a look at both the benefit package that you have in there. I mean it just doesn't seem to me that ours is wrong and it's costly and yours is good and it is not so costly when you're talking about the same basic essential services.

Ms. STEELMAN. We are not talking about a full Medicaid benefit package. We would like obviously——

The CHAIRMAN. How does your benefit package differ from ours then?

Ms. STEELMAN. In terms of Medicaid, it would simply be restricted to out-of-hospitals primary, preventive, and ambulatory services on a first-dollar basis. Hopefully, it would be constructed so that it would cost about $50 to $60 a month, which the State could subsidize according to income.

The CHAIRMAN. So, what is the cost to the States?

Ms. STEELMAN. Between $2 billion and $4 billion on current Medicaid matches. That is the total cost.

The CHAIRMAN. Well, this is the point. I mean you can level it and say you've got the magic program and ours is costly. Now yours is not so costly, so you just shift it over to the States.

Ms. STEELMAN. We simply, quite honestly, would not take care of the range of services that your bill suggests. Clearly, your bill would be appropriate in——

The CHAIRMAN. Which services? In terms of your belief in essential coverage, which services don't you think are essential in ours?

Ms. STEELMAN. I said I support your services if we had a budget environment that would enact those next week. We have tried to look at those services which are most psychologically off-base when a person faces a $250 deductible, that they don't have to get a cold checked out, that they don't have to have a physical, that they don't have to have their teeth checked or their eyes checked.

We have tried to look at just basic preventive diagnostic services. For services other than that, for actual treatment, under our proposal a person would in fact be liable. And that is where the Medicaid spend-down comes into play, that once a person spent too much out of pocket, they would then of course be eligible for Medicaid.

It is a wrap-around to private coverage. I don't think the basic points are missed, though, that clearly we have tried to structure something that is more fitting with the current budget debates, but eventually in a perfect world would support your Medicaid proposals for the poverty population.

The CHAIRMAN. OK.

Senator Kassebaum.

Senator KASSEBAUM. First, I would just like to say I value the constructive and creative suggestions put forward. I have some problems with mandating benefits, and yet as we have all said, we recognize there is a problem. And I think being able to put it in the larger context of comprehensive long-term health care, of restructuring of all of our health care delivery systems, is terribly important.

I am cognizant of the chairman's comment, "Well, how long can we wait while we work with these concepts?" And that is true. Perhaps the best thing is to look at long-term goals, which I think absolutely essential, given changing demographics and a changing workplace structure. Many more people, for example, are working out of their homes in self-employment. Even in cases where they are working for companies, they are doing so on a contract basis. What type of health benefits then will they have or should a company require for those who are contractors?

I see a lot of changes occurring that we are going to have to try to address, I think, in a major restructuring. So, whether for the short term it should be, as you say, the stripped-down package, I don't know. I am really here more to learn because I have not served in prior Congresses on any committee that has dealt with this. I have, of course, followed it for my own interest because I believe it is such a crucial issue facing us today.

I wonder if, in your talking about the stripped-down package with Medicaid being offered by the States, there are not some different ways that we can look to more constructive approaches, working with the States. Again, you know, it's robbing Peter to pay Paul, there is only a certain amount of public support monies.

But I think that States, because they were running short of funds, looked to the Federal Government to finance more health care costs in the past. We are now looking for ways to go back to the States. And it seems to me that this is an area where we have moved from the old county community health systems, because of the stigma of helping the poor.

That is something I think we need to remove. Good quality health care must be offered with a combination of funding to cover those who fall between the cracks. And I don't think that you can just say the poverty level of income, because there are many people who are above that who have either just lost their jobs or have moved and have lost benefits and then don't have any coverage. And I think theirs is just as tragic a situation as poverty level.

So, I guess I only salute you for working to try to construct some suggestions that we can work off of, and I look forward to studying those and others before the committee.

Thank you, Mr. Chairman.

Ms. STEELMAN. Thank you.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

First let me ask some questions just as to clarification. I was under the impression that most employers did offer health insurance. Did I hear you say something different from that, that most employers do not?

Ms. STEELMAN. No. That's correct, most employers do offer health insurance. Ninety-eight percent of those with over 100 employees offer health insurance. Most with under 100 employees still offer health insurance. Of course, that percentage decreases with the number of employees.

Senator DURENBERGER. Then right near the end of your statement—and I forget exactly what topic you were on; maybe you remember—but you said something about employers had done a lot better than Government or something——

Ms. STEELMAN. In terms of containing costs.

Senator DURENBERGER. Containing costs?

Ms. STEELMAN. Employers have been in the vanguard in terms of initiatives to contain costs. They have been successful only with regard to those elements under their control, such as the type of benefits offered, going from first-dollar coverage to small financial incentives.

With regard to those elements outside their control, they haven't been the least bit successful. And of course, that's where the cost share really plays a significant part. Medicaid and Medicare both reimburse basically at levels under cost today. It has been done so quite determinedly over the last ten years, and much of this cost share has been attributed by even some conservative estimates to add as much as 20 percent to the payroll costs attributed to health plans for employers.

So, I think it's no wonder that they are crying to Government to do better.

Senator DURENBERGER. When you talk about employers, it is such a broad universe. And I trust your judgment because you are so familiar with this. But while I have seen examples of employers putting in some place some utilization controls and so forth, I guess I wouldn't come to that same conclusion that they have done a lot better job.

I think we for some perverse reasons in Medicaid—and that is one of the reason we are here—I think we have done a good job of reducing costs, but we are denying people services.

And in some other areas, putting in the prospect of a pricing system in hospital care and so forth, I think we have done some other things.

And I don't see that—as someone mentioned earlier, automobile manufacturers, they are the ones who always lecture us on how to do cost containment, and yet most of them are still sitting there using up huge tax subsidies for huge insurance plans that nobody in those companies really needs other than they have always had them and so they insist on using them.

So, that was a sort of a point of clarification.

Ms. **STEELMAN**. Well, everything is relative, clearly. But at least they have done a better job of containing their health costs while still offering benefits, something that the Federal Government, as you point out, hasn't been quite as good to do.

Senator **DURENBERGER**. The issue that you and Senator Kennedy were discussing about the role of the States and local Governments and the changes in Medicaid, if I understand your proposal, it is that in effect we ought to buy a preventive health plan and then let the States add to that. Is that sort of the way yours would work?

Ms. **STEELMAN**. Yes.

Senator **DURENBERGER**. So that in the Kennedy legislation in fact has some combination of acute care benefits and preventive care benefits, particularly in well-baby care and maternal and child health. So, in effect, the bill before us or the chairman's approach is for us to buy the package, the larger package of preventive and acute-care benefits; yours is to offer up the preventive benefit and then let each State decide how much it will piggy-back on that?

Ms. **STEELMAN**. Well, of course, as is always the case in any discussion of health care, it is more complicated than that.

Senator **DURENBERGER**. Yes.

Ms. **STEELMAN**. What we try to do is define a public package and a private package that will interact effectively without overlap. Our main concern about the chairman's package is that there is significant overlap and adverse incentives to jump from one program to another. We have tried to eradicate that.

So, our design obviously is to try to get to the same benefits with the least amount of cost for either the State or the low-income individual, but ours is simply structured in a more interactive way.

Senator **DURENBERGER**. What I am trying to get to is how all of this is perceived from the standpoint of the people who are going to get up on the next panel and testify. I mean are they going to get a health insurance policy just like working folks who have employers who will buy it for them, under your proposal? In other words, would you buy a health plan out there in the market of preventive benefits and then suggest that each of the States in some way or another supplement those benefits by paying a portion of the premiums that reflect the cost of acute medical benefit?

Ms. **STEELMAN**. Basically, for a low-income person, what they would be offered is we would get rid of the ERISA preemption, allow insurers to offer a low-cost core benefit package that would have higher deductibles and make it a cheaper package.

But because we do not want to erect that barrier to care for those same people, we would change Medicaid as it applies to them because offering Medicaid's full benefit package is simply too expensive to be discussed in today's budget context either at the State or the Federal level, we would try to figure out how we could offer benefits that would give them access to care so they wouldn't be convinced not to seek that care by virtue of the deductibles in their private plan to go get private care, stay healthy. That's the basics.

Senator DURENBERGER. Yes.

Ms. STEELMAN. Then, when something goes wrong——

Senator DURENBERGER. Yes, the point I am trying to get at is the vehicle, and we can at some other time talk about who puts in how much money. But let me take you to something that I think I understand, which is the experiments we have been working on with competitive medical plan for Medicare, which is the other part of the public part of this problem.

The elderly buy two or three or four insurance plans right now. They get to buy a Part A plan, then they get to buy a Part B plan, and then they may have one from their employer which is now secondary to Medicare, and then they buy whatever the movie actors sell them on television or used to sell them or whatever.

And the competitive medical plan approach was so these people could buy only one health plan, and its premium would be supplemented by some of these other actors. And it would be the person's choice to add benefits, but it would only be one plan.

So, looked at from the standpoint of an elderly person, they bought their Blue Cross plan or whatever it is plan, and the Medicare would contribute a certain dollar amount to it and an employer might contribute a certain amount to it, they might contribute a certain amount. As they expanded the benefits, there would be a variety of contributors.

Is that, in your opinion, possible or appropriate for us to approach the lower-income person, the people who traditionally rely on Medicaid, those who are losing out because they don't qualify for Medicaid but who are low-income? Would it not be possible that we approach financing access for those lower-income people on the same basis? In other words, they buy a health plan and we might make a commitment to buy some set of the benefits for them and somebody else would add to that benefit? Is that a possibility?

Ms. STEELMAN. Absolutely. That is the provision that I noted under what we call the Medicaid buyout, where an employer can make the decision to offer insurance to his employees. And we have one employee who simply cannot afford to buy it, the State would subsidize that premium.

That is not exclusive, either-or. Both of these would be available to people under the 150 percent of poverty. One would apply where the employer does offer insurance, one would apply where the employer either offers the low-cost prototype plan or none at all, and we still want to make sure that person gets the preventive care available under the stripped-down Medicaid provision.

Senator DURENBERGER. Now, the follow-on question to that relates again to the dollars because in this committee we have spent a lot of time dealing with child care, for example, and we are debating whether we are going to do $2.4 billion or $2.0 billion or something like that. Child care benefits, we are already spending, I think, at the Federal level something like $7 billion a year on child care. And so we are just sort of adding a little dimension to that.

Now let me ask you that same question regarding existing health benefits. If, in effect, we were able to buy preventive health benefits on some basis that we have been discussing, what is your view of what is going to happen to all of the current investments that are going in through the Public Health Service into preventive health care now or health treatment, drug abuse treatment, mental health, substance abuse, a variety of these things?

There is a lot of money being spent at the Federal level already for persons who, I take it, get access to these services because they are at the lower end of the income scale. Have you thought about what happens to all of that investment, or is that not a pool that we can go look to for some of that?

Ms. **Steelman**. Well, first, Medicaid, of course, only covers about 40 percent of the eligible population today, the population under the poverty line. So, we have an awful lot of improvement to make there.

In terms of our direct provision through either community health centers, drug abuse, et cetera, clearly we would need to make efforts to make sure there was planning so that we had a cohesive interaction rather than an overlap.

But in general, I think, the funds devoted to those purposes are so small compared to the population that needs them that that is probably the least of our worries.

Senator **Durenberger**. May I ask you a final question regarding the tax subsidies, since I have been asking it of everybody else here this morning?

I take it the mandated benefits come to us courtesy of providers, in large part. They like to see a lot more services, their particular services. And it seems to me that the opposition to changing the current employment-based tax subsidy is coming largely from insurers or health plans who write plans for Ford Motor and Chrysler and all the rest of those folks. Has that been your general observation?

Ms. **Steelman**. I think that there is pretty much universal support for the richer plans. Unions appreciate being able to negotiate for the richest plan possible. Employers like to attract employees by offering rich plans—all of this at the largess of the Federal taxpayers. So, I don't find the support for that provision isolated.

I would just like to add, perhaps a little bit off point, but clearly when you are talking about radical reform, which is where I have come to sit in this discussion, these kinds of issues have to be addressed. And that is probably the main problem with mandated health benefits is that it offers us a supposed solution which is really illusory when we've got far more, even as Elliott Richardson said, systemic problems going on that deserve our attention.

Senator **Durenberger**. Thank you very much.

The **Chairman**. Let me ask, just so I am clear in my own thinking. The problem that I see in this proposal is you are going to be dealing not only with those who are not working but also the working poor. So, the public aspect of your program is really larger in dimension than the one that we have proposed.

And I think we ought to keep track of the fact that what you are talking about as you are concerned about our overall lost, you are talking about providing only out-of-hospital primary, preventive, and ambulatory services. And that does not address what do you say to the person who gets sick and needs to go to the hospital. That is basically what we are after.

I am all for the preventive health care, all for ambulatory care, it's less expensive. We ought to be dealing with the financial incentives to get people out there before they need a hospital; that is all well and good. And I agree with all of that.

But the bottom line on this is that you get a cheaper price because you are providing a lot less services. Everybody is for ambulatory care. You say ours is too expensive, so we are just going to do ambulatory care. And I think, quite frankly, it's unrealistic to think that the four million poor Americans who now are members of families who are in poverty and are being employed today, not to think that those employers are going to say there is another public program to take them out, so we're going to let the taxpayers pick up those.

Then the other part that I hear as missing as I listen to the discussion is saying, okay, well, let us just do this, we'll just do this, and then we will mandate the States to do the rest. And isn't that your program?

So, we can all, you know, get through the eye of the needle in terms of what you want to spend. You say, well, look, we think you can get by with $2 billion or $4 billion, we know what to do in terms of cutting back.

But I think you have a real responsibility if we are serious about trying to do something for those 37 million. Maybe we are going to have to take some time in getting there, but at least give the assurance that when we pass legislation, that inevitably we are going to get the kind of coverage which they need. And I just don't see that in this program here. I don't know whether I am missing something.

Ms. Steelman. It is true that we have a broader-based program in the initial steps with narrower coverage. But if you think of it as a continuum, Medicaid would offer preventive care, which we do think—I think we agree—is more likely to be enacted then a full-blown Medicaid expansion.

The second step would be to have employers be able to offer low-cost prototype plans which would be accomplished through an ERISA preemption, which again I think we agree on.

Then the third step would allow people who are too poor, even with that coverage and end up spending down into Medicaid, we would allow Medicaid to pick up those hospital expenses.

So that we do match as a continuum, and we simply try to make sure that these low-income Americans have access to the preventive care that strictly, under S. 768, with the exception of well-baby care and prenatal care, does not seem to apply.

But clearly we want to head in the same direction.

The Chairman. Good. Well, we appreciate it. You have been very helpful, and we are going to be in this debate, I am sure, for some time and we are going to try to find ways of, hopefully, achieving a little of our objectives of decent care.

I want to thank you very, very much. You have been very generous with your time.

Ms. STEELMAN. Thank you for your leadership, Senator.

[The prepared statement of Ms. Steelman follows:]

PREPARED STATEMENT OF DEBORAH STEELMAN

Thank you Mr. Chairman and distinguished Members of the Committee for the opportunity to speak with you today.

Senator Kennedy, I applaud your leadership in the area of obtaining access to health care for everyone in this country. It is an issue of serious national importance on which your leadership has proved singularly critical.

I also applaud the changes you have made in your legislation. Even though you were successful last year in reporting S. 1265 from this Committee, it is clear that you have spent much time and thought in addressing some of the weaknesses in that legislation.

However, it appears that the very improvements to the bill serve only to underscore the primary difficulties of last year's bill, both of which have been retained: the mandated benefit approach in general, and the lack of any significant proposals, or even a focus, to address the exploding costs of health care in this country.

MEDICAID EXPANSIONS: REAL OR IMAGINED?

The legislation before the Committee this year does recognize the need for a government subsidy to provide health coverage for our poor and near-poor, and some of the Medicaid expansions proposed for these populations are welcome.

However, the state program envisioned goes well beyond the public sector's responsibility. The program would lead to the unnecessary and costly substitution of public coverage for private coverage. For example, higher incomes persons would be eligible for the public program, people who are in most cases more than able to afford existing private coverage on their own.

In addition, the envisioned public structure (open, voluntary enrollment) will experience tremendous costs due to adverse selection over time. Only the sickest individuals (willing to pay the income related premium) will likely enroll in the plan. This in turn will drive up the cost of public coverage which will either be paid by government or cause the healthier individuals to flee from the program, thereby driving up costs of coverage further (an adverse selection spiral).

Clearly, at a time when government has failed to live up to its obligation to the poor, it is questionable whether 11 short years from now it will have the fiscal capacity to pay substantial amounts for coverage of the nonpoor, even if by then it has adequately addressed the unmet needs of the poor.

This is a big if, as we know. This year's budget agreement fails to address their needs in any meaningful way. The unmet needs caused by the inability to obtain a national concensus, or even any statewide concensus, to raise the funds for Medicaid expansion are tragic. But these unmet needs do not call for the enactment of mandated benefits legislation, a proposal that simply cannot meet these needs. This is like looking for the $10 bill under the lamppost instead of where it was lost; you may have light but you won't find anything.

Shouldn't we concentrate on where we lost the $10 bill, on the areas where we may find some real answers? First, let's address the unworkable nature of mandated benefits; then let's look for the $10 bill where we lost it.

THE PROBLEM WITH MANDATED BENEFITS: FOR LOW INCOME WORKERS, MARGINAL EMPLOYERS, AND FOR HEALTH CARE COSTS

The problems with mandates are their lack of flexibility, lack of market recognition, and inability to deal with the real reasons health care coverage may not be offered by an employer. Affordability is the principal barrier to health coverage; a mandate does nothing to alleviate this burden. If anything, affordability concerns would be heightened as businesses (and their employees) would be forced to buy coverage even if their current budgets dictate otherwise.

The mandate will clearly reduce private sector plan design flexibility, and will substitute the decisions of union and employer employee benefits managers with government personnel. Employers currently providing health coverage -- including large employers -- will face plan design changes and restrictions resulting in a loss of flexibility from the perspective of both management and labor. Government can be expected to seek further controls over the terms and provisions of the mandated plans (e.g., similar to section 89).

LOW-INCOME WORKERS

Most uninsured persons have a relationship to the workplace, but three-quarters of the employed uninsured make less than $10,000 per year. For a moment, let's make the very reasonable assumption that the public program that would subsidize the copays, premiums, and deductibles for those under the poverty line would not phase in as quickly as the mandate.

While the 80% premium match might allow the monthly premium deductions to be affordable to this group, the employee's share could still cost those earning $10,000 more than 4% of their income. While this may not sound like much, consider that the median income for American families is $30,850, and their contribution to health coverage totals less than 1%. For the family earning less than $10,000, every dollar is twice as dear.

The provision requiring employers to pay 100% of the premium for those earning less than 125% of the poverty line is more likely to happen in the first year because it has no budget impact. Still, this legislation is beyond the means of this population, people under current law today earning less than approximately $7,000 per year. The $250 deductible alone is a tremendous barrier to care, as those offering and buying such plans today already know. And for those earning above $7,000, a $250 or $500 deductible and a 20% copay may mean paying over $2,000 for this coverage. This is simply unaffordable to low income Americans.

MARGINAL EMPLOYERS

While most of this testimony centers on the health policy problems with this legislation, some mention of the lack of affordability to employers is required. Most of the employers of most workers at these very low income levels are businesses also at the low end of the income scale. Two-thirds of all bankruptcies are in the service and trade industries, and about two-thirds of all these bankruptcies are among small firms. This legislation's provision to hold harmless those businesses whose costs exceed 5% of their gross receipts show the legislation wasn't put together by a business person; such a business is already bankrupt.

Here we have the true tragedy associated with mandating benefits: there is no wage flexibility at the bottom of the pay scale; to do so is illegal. And, at the point there is no give in the wage, and no give in the benefit, there is only give in one place: the job itself. For the population in question, trading health care for a job is not only an impossible choice for them, but should be for policymakers as well.

HEALTH CARE COSTS

The costs of providing health care coverage are putting more and more employers in precarious positions. This bill offers no proposals to counteract a dangerous trend: over the last 15 years healthcare expenditures in the U.S. have risen at an average annual rate of 12%. The main causes of this substantial growth are associated with demographics, new technologies, consumer insensitivity at the point of demand, and ambiguities over appropriate medical practice standards, leading to overutilization of certain procedures, particularly in the face of growing malpractice suits.

But perhaps most significantly, Medicare and Medicaid payments to providers have been reduced below costs, and the providers have responded by shifting the shortfall to private payors. Conservative estimates suggest that this factor alone has helped to raise private sector healthcare costs per employee by about 20 percent annually over the last two years.

Consequently, health benefits have become more expensive, accounting for about 10% of employer's payroll. More importantly, for the marginal employer, health benefits have become increasingly difficult to afford. This legislation only increases the cost even further to that marginal employer.

This legislation's uniform regional/state rates will create tremendous cross subsidization from areas with lower health care costs to areas with higher costs. Variations in the cost of health care coverage between regions or states often pale in comparison to those experienced within state borders. In addition there are strong economic arguments for why the rate structure is bad. Such a structure completely breaks the linkage between costs generated by health care use and what an employer pays for coverage. It therefore eliminates incentives, and perhaps even the ability, for employers to seek out the most efficient, cost effective local providers and financing and delivery structures. It also reduces the incentive for employers to offer preventive health strategies to their workers.

The lack of cost containment features, while noted by the legislation's sponsors, are nonetheless inappropriate. While the reasoning behind the lack of copays and deductibles for people under the poverty line is appropriate as far as access to care is concerned, it fails to acknowledge that overutilization can be a problem in this population as well as all others. Why is there no mention of case management techniques to insure appropriate utilization? Why no studies for protocols or technology assessment to help assure appropriate care? What competition would exist within the stated regional pools to drive costs down?

BETTER ANSWERS FOR THE UNINSURED: MEDICAID AND THE PRIVATE SECTOR

Now, where might we find the $10 bill? First, at least in spirit, I agree with Senator Kennedy's outline for Medicaid expansions. And we can find ways to fund major improvements in the funding base of Medicaid, although that task requires much more thought and creativity than has been applied to date.

The uninsured problem is complex and broad-based, but the one thing that comes through clearly is that it is strongly correlated with poverty. Characteristics of the uninsured:

- The uninsured are a heterogeneous group, pointing up the need to come to the table with a series of solutions.

- The uninsured are almost equally split between poor (less than 100% poverty), near poor (100-200% poverty) and nonpoor (greater than 200% poverty).

- Three-quarters of uninsured workers make less than $10,000 a year.

- Approximately two-thirds of the uninsured are either full-time workers or their dependents. Approximately 11% of the uninsured are either self-employed workers or related to such persons (16% of uninsured workers are self-employed).

- Uninsured workers are disproportionately located among three industries: services, retail trade, construction (28%, 24% and 10% respectively). Retail trade and services are on average lower wage, and construction is seasonal.

- A small portion of the uninsured are those who can afford insurance and want to buy it, but cannot due to a chronic health condition (such as AIDS, heart disease, cancer, etc.). According to the American Medical Association, there are about 1 million uninsurable individuals nationwide.

The increase in the number of the uninsured is associated with an array of complex causes: the precipitous decline in Medicaid coverage; the growth in healthcare costs, including the impact of government cost-shifting; and general economic, sociological and demographic trends. Between 1975 and 1985 the number of the uninsured increased by about 50%, on the order of 10 million people.

In other words, the problem is broad-based and complex, but the one thing that comes through clearly is that it is strongly associated with poverty.

This year, there will be great fanfare over minor increases totaling less than $500 million, nationwide, to the Medicaid program. The Medicaid program cannot be righted, nor accomplish the goals stated in this legislation, without $10 to $12 billion. We have not seen any domestic program increases of this size at either the state or federal level, since the early 70's, and in this program, as noted above, we have seen serious real declines.

Medicaid coverage has decreased dramatically over the past decade to an all-time low (it now covers only 38% of the poor and 40% of the recent increase in the uninsured is attributable to a failure of Medicaid eligibility to keep pace with rising inflation).

- 33% of uninsured are below poverty.
- 33% are near-poor (between 100% - 200% of poverty)
- 75% of uninsured workers earn less than $10,000 a year.

Obviously, the proper role of government and the first priority of a program for the uninsured must be to cover low income individuals through a carefully targeted improved and expanded Medicaid program.

MEDICAID

Recognizing the history of Medicaid's past 15 years, and the budget-conscious decisions of years to come, how can we find answers better crafted to meet the real needs of this population and budget goals as well?

Instead of moving toward an untargeted and expensive expansion in Medicaid coupled with an unworkable mandate, Medicaid should be built up on more precise and less expensive criteria, coupled with a private sector expansion more surgically designed to improve coverage to the various populations in need and their unique circumstances, without impairing the coverage available to already insured Americans.

Medicaid eligibility should be broadened to ensure that all persons who fall below the poverty line are covered irrespective of age, disability, family or employment status with first priority given to coverage of pregnant women and children.

- Eliminate categorical restrictions.

- Uncouple Medicaid eligibility from welfare cash eligibility.

Next, creation of a broad Medicaid buy-in would enable the near poor (e.g., income from poverty up to 150% of poverty) to pay an income-related premium for a limited set of Medicaid services, limited to out-of-hospital primary, preventive and ambulatory services on a first-dollar basis. This would address the problem still posed by the mandated benefit deductible of $250.

- Such limited benefits would cost $50-$60 per month for a family of three.

- Would cost government substantially less than expansion of full Medicaid coverage (Preliminary estimate of $4 billion for all near-poor).

- Limited benefits would cover the most necessary and effective care for the near-poor.

To assist these people with extraordinary expenses, we should allow persons otherwise ineligible for Medicaid (for income reasons) to obtain full Medicaid coverage once their out-of-pocket medical expenses reduce remaining income to federal poverty level. This is patterned from the old practice of a Medicaid spend down for long term care.

Building on these pieces, we could also allow the states to save costs by allowing states to pay premiums of poor and near-poor (up to 150% of poverty) workers to enroll them in employer plans (when such coverage is available). This concept, a Medicaid buy-out, is already embodied in the 1988 Welfare Reform.

- Allows expansion of coverage to poor and near-poor workers at a more moderate (and predictable) cost to government by encouraging the use of existing private plans.

- Improves the interface between public and private forms of coverage.

- Medicaid would still be available (as a "wrap around") to cover deductibles and items not covered by employer plan.

All of these reforms should be combined with improving provider participation in the Medicaid program and more federal flexibility for the administration of the states' programs. Waivers are practically impossible for the states to wrangle through the federal bureaucracy.

The federal government must not only allow, but must encourage simplified administration and presumptive eligibility, improvements in reimbursement rates, targeted malpractice reform, and modern cost containment/quality techniques, particularly case management. Treatment practice guidelines and quality outcome measurements should become as large a factor in Medicaid as in Medicare and private insurance.

THE PRIVATE SECTOR

To expand the availability and affordability of private insurance, several concepts appear more effective than employer mandates. Insurers should be allowed to sell lower cost core benefit prototype plans by eliminating cost-inefficient state service and provider mandates. This could be accomplished by extending to insured employer plans the very same freedom from state mandates now enjoyed by self-insured plan.

- Would make coverage more affordable.
- Allows employers and consumers to buy plans directly suited to their financial and health needs.
- Should reduce the uninsured by the 9.3 million attributable to such state mandate laws.

For uninsurable employer groups, establish a private reinsurance mechanism. Losses from the reinsurer would be spread equitably.

- Establish a residual mechanism to ensure availability or coverage to all employers.
- Ensures more affordable plans for employers otherwise faced with very high cost coverage.

For uninsurable individuals, establish state high risk pools financed by general revenues or other broad-based funding. HHS should have the authority to establish pools in states which fail to do so themselves.

- Would ensure availability of coverage for high risk individuals.
- The total number of uninsurables is estimated at one million.

Extend to the self-employed a full 100% (currently only 25%) federal tax deduction for the cost of health insurance so long as they provide equal coverage to their employees.

- Would make coverage more affordable for small, self-employed businesses.
- Would eliminate the inequity between the self-employed and incorporated firms (currently, corporations receive a full 100% tax deduction).
- Would apply to approximately 4 million uninsured.

Gaining access to health care for all Americans is one of our most important national challenges today, and I deeply admire and appreciate your dedication to this cause, as well as your staff's and those who support your bill. While we disagree on what will actually solve the problem, I look forward to working with you and others toward a solution that might eventually help the millions of unisured Americans in our country today.

You and your colleagues on the Commission on Long-Term Care and Comprehensive Care have a great opportunity to find the real solutions and to build the consensus necessary to enact them. I suggest that none of them are on the table today. All of us in this hearing room, and millions of people around the country, hold great expectations for the Commission's work and wish you Godspeed.

The CHAIRMAN. We have as our next witnesses representatives of the millions who have no health insurance at all. They have agreed to come here and talk about their personal situations, their families, their hardships, their uninsured medical expenses.

We thank them for coming. We look forward to their testimony. We will hear from Ms. Eva Phillips from Takoma Park, Maryland.

Senator Mikulski has a statement of welcome for you, Ms. Phillips. She very much wanted to be here, but she was unable to be here.

If you would be good enough to come up.

Then we will hear from Mary Reich, from Naperville, Illinois.

Senator Simon also has a word of welcome.

And then from Maria Mendez, from Denver, Colorado. Mrs. Mendez is accompanied by her husband, Angelo, who will translate his wife's testimony.

And there is little Yvett, who is also here. We are glad to have Yvett as well.

OK. We will start off. Ms. Phillips, maybe we will start with you.

STATEMENT OF EVA PHILLIPS, TAKOMA PARK, MD, ACCOMPANIED BY MARY REICH, NAPERVILLE, IL; ANGELO MENDEZ, MARIA MENDEZ, AND YVETT MENDEZ, DENVER, CO

Ms. PHILLIPS. Good morning. First of all my name is Eva Phillips. I am 41 years old, married, mother of three young men. And I would like to thank the panel for having me here this morning to talk to you about an issue of very grave concern to me.

Both myself and my husband work for the past 20 years in nongovernmental jobs. Even with both our incomes, we cannot afford family health. Both of us always have jobs with mid-sized companies which ordinarily have no health care benefits because they say they can't afford it.

OK. You see, my family is what you call "falling between the cracks." The reason that we fall between the cracks is because most of my adult life I have had asthma, arthritis, and glaucoma and never been able really to be well to get to work or to afford health care or preventive health care.

For example, the cost of being sick and not having health care is, for me for the past two years alone, I have been in the hospital twice and both times I have been in there for a maximum stay of ten days and with pneumonia each time I have been in there. So, this is how it's worked for me.

The total costs of the stay was $9,700 for ten days altogether I have been in the hospital. I still owe $4,000 on these bills alone. Doctors visits for the past two years total $1,140. I still owe $500 on that. For this amount, for the monthly cost of prescriptions alone, I take Theophylline for asthma. That runs me $22 a month. I have glaucoma and I take Timoptic, and that is $45 alone. And Fixarole, which is just something to keep me mobile for the arthritis, and that's $15.

As you can see, my health care is something that I must have, and yet can't afford. The monthly income of my household is $1,260. The monthly nonmedical expenses—rent, electric, gas, car, life insurance—total $573. We also pay $75 per month on outstanding hospital bills, plus monthly prescriptions which total $157.

All of my family total income—expenses are $730. As you can see, out of $1260, you can pay out $730 a month, which leave $530 for food, transportation, and other living expenses.

Our monthly income is $100 over for supplemental care. And my husband's employer cannot—says he cannot—afford health care benefits and salaries too.

We have looked into buying our own health care insurance but could not afford the cost because it was over $300 a month for family coverage.

This is why I am here today to ask the Senate committee to please give people like me and my family the health care we need.

The CHAIRMAN. Thank you very much, Eva.

Let me just ask a very few questions and then we will go on to our other panelists.

You mention that you are the mother of three young men. Can you tell us how old they are?

Ms. PHILLIPS. I have a 21-year-old, 22-year-old, and an 18-year-old.

The CHAIRMAN. And are they living with you?

Ms. PHILLIPS. Yes, they are.

The CHAIRMAN. And are any of them working?

Ms. PHILLIPS. I have one that is working; that is my 22-year-old. And he works for the Hecht Company.

The CHAIRMAN. Does he have health insurance through the Hecht Company?

Ms. PHILLIPS. He has health insurance but it does not cover me or the household.

The CHAIRMAN. So you are not covered under that program.

And your husband's employment, where does he work?

Ms. PHILLIPS. He works for a plumbing warehouse company.

The CHAIRMAN. Do they provide any health insurance at all?

Ms. PHILLIPS. They said they can't afford to pay salaries and insurance too.

The CHAIRMAN. You mentioned your health problems and the fact that you have never been able to get really well because you are unable to afford health care, especially preventive care.

As I understand it, your total family income is $100 over what the——

Ms. PHILLIPS. What the county would allow——

The CHAIRMAN. What the county would allow.

Ms. PHILLIPS [continuing]. Or subsidized medical care.

The CHAIRMAN. Do you ever think of you or your husband either not working or getting a lower compensation so that you would qualify?

Ms. PHILLIPS. Well, no, because then you are still defeating your own purpose or your whole general purpose of life is you are going to say, well, the Government will take care of me. I don't want the Government to take care of me. I want to be able to have a program where I can go in to a doctor and say, okay, I can't pay you all of it but here's a sliding scale for me, and I can afford it.

Otherwise than that, I am defeating working.

The CHAIRMAN. OK. We might come back. I want to thank you very much.

Mrs. Reich.

Mrs. REICH. My name is Mary Reich. My family consists of myself, age 42; my husband William Reich, age 50; my daughter, Catherine Bodnar, age 13; and our daughter Caryl Anne Reich, age four months.

After experiencing several years of unemployment part-time employment, and self-employment, my husband was hired by a small firm which deals with micro publishing, and he has approximately 45 employees at any given time. He is employed as a driver to pick up and deliver materials to the various clients who use these services.

Bill took this position in order to have a steady job with insurance benefits. The benefits were not fully explained at the time he was hired. When he signed up for medical benefits, we were surprised to find out that we would have to pay for the coverage.

As with most insurances, there was a 90-day waiting period for eligibility and a preexistence clause. However, we still found the amount of our premium to be high. We checked with several friends who are insurance agents, and they told us that the cost was a little high, but not out of line with the coverage that we had.

The cost has been $127.02 per biweekly paycheck since August of 1988. As of March 15, 1989, our coverage was changed, and as of May 5 our premium will be raised to $194.75 per paycheck.

If Bill made a decent salary, maybe we wouldn't feel the financial crunch. As it is, he is making $5.75 an hour and $127.02 is approximately 27 percent of his gross check. This percent has varied depending upon the number of hours worked. When he had lots of overtime last summer and early fall and I was working part-time, we didn't really feel the pinch. Without overtime and my income, which has stopped since I had to quit to have the baby, we have had to apply for public aid. We do receive food stamps and a medical card for my daughter Catherine. We have had to receive help from the township, Catholic Charities, St. Peter and Paul Parish, IHEAP, the WIC program, the well-baby clinic, the St. Vincent dePaul Society, Loaves and Fishes food pantry, and FISH, a nonprofit organization.

My husband, the baby, and I do not qualify for a medical card on a regular basis. Even on an emergency basis, we would have to spend down approximately 58 percent of our gross income before public aid would pick up anything. Because of the preexistence clause, the bills relating to my pregnancy were not covered by our insurance, and public aid did not pick up the first $721.89. The baby's bills were partially covered by our insurance, but there is still a large amount not covered.

Because of the preexistence clause, we are faced with staying with our current coverage or not having any insurance at all. The baby was born with a congenital heart defect known as mild pulmonary stenosis. When we investigated the possibility of carrying an individual policy, we were told that no one would touch us because of the heart defect.

If the defect does not get worse in five to ten years, we might be able to get different insurance coverage. The premiums on an individual policy would also be 25 percent higher than our current costs because I am a Type B diabetic, and some other problems would not be covered at all or at least for a period of time because of preexistence.

If one or both of us could find full-time employment with insurance benefits, we still might not be able to get coverage for the baby. Because of our circumstances, we have requested applications for CHIP. If the cost of CHIP is less than what we are paying now, it might be worth changing to it.

We are not alone. There are many people, both singles and families, who are experiencing the same type of problems regarding insurance coverage. Our problem is compounded by age and preexisting conditions. The uncertainty of the situation compounds our lives further with stress and tension, making a decision almost impossible.

How do you decide whether to stay insurance-poor or wait for financial ruin? In either case, we are financially ruined. Neither my husband nor I have ever experienced this situation before. When we were previously employed by larger companies, all or most of the cost was covered by the employer.

However, the rising costs of insurance coverage has left the smaller companies with few choices. Most have turned the responsibility for premiums over to employees, leaving the employee with the burden of a weighty decision.

I do not envy you. The question of whether employers should be required to pay all or most of the cost of insurance coverage is monumental. Your decisions will affect the lives of many, both individuals and companies. I do know what it feels like to be on the one end. Low wages compounded by deductions leaves us below the poverty level. We are behind on all of our utilities, our charge accounts have been closed for lack of payment, and we have a number of outstanding medical bills. We do not have car insurance.

We have come to an agreement with our landlord regarding our rent. Bill will do handy work in exchange for part of our rent. We realize that your decision will probably not change our situation in the near future. So, we must still make this decision. I feel that it isn't very often that legislatures go to the low man on the totem pole for an opinion regarding changes. Thus, this opportunity is greatly appreciated. Thank you for listening to one of the insurance-poor people.

The **Chairman**. Let me ask you just a few questions, Mrs. Reich. I want to understand one of the points that you make in your testimony. You say your husband's employer does make a health plan available to his employees? Is that right?

Mrs. **Reich**. Yes, sir.

The **Chairman**. But the employer doesn't contribute anything to pay for the premiums?

Mrs. **Reich**. No, sir.

The **Chairman**. And it is as a result of that that it is going to cost your husband almost $400 a month pretty soon?

Mrs. **Reich**. It will be—it averages out to $450 per month, which is 43 percent of his gross pay if he works a full 80-hour paycheck.

The **Chairman**. How much are the total medical expenses as a result of your child's congenital heart defect?

Mrs. REICH. At this point, as a result of the heart defect for her, her outstanding bills are about $1200 and my outstanding bills are about $1500 and they are going up. I have to have surgery on Wednesday, and I don't have any insurance to cover it because of the deductible, the change in deductibility.

The CHAIRMAN. Have you considered some kind of a day care program for the baby so that you could look for employment yourself?

Mrs. REICH. I have, and the minimum cost is $102 per week, which is not cost efficient for me to go to work.

The CHAIRMAN. All right.

Mrs. Mendez, we want to welcome you and your husband and your seven-month-old young lady of yours to join our hearing today. We look forward to your testimony. I understand your husband might help and read that testimony for us.

[Mrs. Mendez addresses her statement to the committee in Spanish.]

Mr. MENDEZ. [translating for Mrs. Mendez] My name is Maria Mendez. I am 36 years old, mother of six children, and I am here today with my husband Angelo and our seven-month-old daughter Yvett to explain to you the tremendous hardships we are facing because we do not have health insurance.

I have a job cleaning office buildings 25 hours a week, for which I earn $4.45 an hour, for the company named B&G Maintenance. I am a member of the Service Employees International Union, and through our union contract I also receive paid vacation and holidays. But my family and I do not have health insurance.

Very few people who work as janitors have health insurance, and this is a genuine burden, and my story is just one of millions.

When I became pregnant with Yvett almost a year and a half ago, we did have some health coverage through my husband's job. I was able to go to Kaiser HMO office for my prenatal visits, and that was great because I had a high-risk pregnancy due to my age and complications. I had miscarriages before.

Then all of a sudden Angelo was laid off and everything changed. No more Kaiser. Instead we have to go to the Five Points Clinic in Denver, wait in line to see a doctor. We also had to pay $20 a visit out of our pockets, and we had to pay first before we could see a doctor. We were charged a certain amount for things like ultrasound, which had to be done to make sure the baby was okay.

The real blow came when the baby came. We almost died when we got the bill from Denver General. It was over $6000. Part of that was because of the nurses mistakenly gave me a meal while I was still on special postdelivery medication and I had a violent reaction. I had to stay on additional days in the hospital.

So, now we have a beautiful baby girl. But we also have this huge bill, which we try to pay off at $75 a month. At that rate it will take about six and a half years to pay it off.

We also have very big concerns about our other children. Before, when Angelo had Kaiser coverage, we would bring them to the doctor when we didn't know what was wrong with them. And it's sad to say, but now we can't afford to take them unless it's for something serious.

Last fall, my oldest boy, Jorge, had a virus, and he became very dehydrated. We tried to give him medication from the drugstore, but he got sick and wouldn't eat. Finally he got so bad that my husband had to rush him to the emergency room. They kept him for several hours and put him on an IV machine.

I think if we had insurance, the doctors might have kept him overnight to make sure he was better. But since they didn't think we could pay—and they were right—they released him. It took several days at home for him to get better. The bill for Jorge came out to about $850.

We also have medical bills from before, and now we are getting the notices from the collection agencies. Do you know the feeling of getting these notices every few weeks? It is very degrading, especially when you can't see any way to find the money to pay it.

My husband and I are very proud people, and since his layoff he has been working almost every day at odd jobs as well as going for job applications. And we have been able to get by. As it is, we now have to get food stamps. That helps out, but we do not want to go on welfare. We want to get jobs that give us some health coverage.

People with good-paying jobs and good benefits probably do not have to pay as much for their medical bills as my husband and I do. We are hardworking people, and it just doesn't seem fair.

If we could, we would spend the money to have the children's teeth fixed and buy them new clothes, but as parents we feel bad that right now we are not able to provide these things.

She would like to make a closing remark.

[Mrs. Mendez addresses the committee in Spanish.]

Mr. **Mendez**. We continue to look ahead because we have faith, our faith in God, and we feel things can't get much worse. But I guess they could if someone else in the family became ill. With six children, it is always a possibility.

We hear a lot on the news about the problems of people like us who work hard but do not have any health insurance. Even though people realize that it causes real suffering, there aren't any solutions. That's why we thank Senator Kennedy for all that he is doing, and we hope that you and your committee can come to a solution.

The **Chairman**. Well, thank you very much.

We want to thank you very much, too, Mr. Mendez, for telling us the stories. As we all understand, it is never easy to talk about some of these health difficulties that the families have. I think most of us by nature and disposition feel that those issues ought to sort of remain with ourselves or just within the family. But the fact that you have been willing to tell us about your own life's experiences has been enormously helpful and valuable because it is being replicated every single day, every hour of every day in so many parts of our Nation.

Mrs. Mendez, I have just a few questions. Have you considered looking for a different type of job, perhaps a job that has health insurance?

Mrs. **Mendez**. Yes.

The **Chairman**. Is it difficult to find?

Mr. **Mendez**. She knows that there are those type of jobs there, but right now she can't get it because she doesn't speak English that well and she, as soon as she learns English, she hopes that she will be able to do that.

The **Chairman**. Now, I am sure you have some acquaintances who are doing the same kind of work that you do. Do your friends who do the same kind of work, do they have health insurance, or do they have the same kind of problem that you are having?

Mr. **Mendez**. She says my friends also do maintenance work don't have any health insurance either.

The **Chairman**. How many children do you have?

Mr. **Mendez**. We have six children.

The **Chairman**. Six children.

Let me ask you, Mr. Mendez—we appreciate your coming here with your wife and helping us out with the translation—what kind of job did you have before you were laid off?

Mr. **Mendez**. I was a union organizer.

The **Chairman**. What kind of odd jobs are you doing now?

Mr. **Mendez**. Well, I have been, on the side, I have been having an independent contracting, trying to sell U.S. Sprint. I have worked on a lunch truck. I have worked as a janitor. I have worked as an independent contracting janitor. I have had all kinds of work.

This Thursday, as a matter of fact, I have an interview for a job possibly with the city as a probation officer. So, I am hoping that will work out.

The **Chairman**. But you want to work.

Mr. **Mendez**. Definitely.

The **Chairman**. And you want to make sure that your wife and your family are covered with some kind of health insurance.

Mr. **Mendez**. Like I said, when I had it before, it was the fact that we could take the children to the hospital, the clinic, just to make sure that they didn't get sick, just for a checkup in case they needed it. Now, unless it's something drastic, we can't afford to do that.

The **Chairman**. Do you, when you hear your children either coughing or feeling a little bad, do you make in your own mind sort of an assessment whether that child is $50 or $75 or $100 sick?

Mr. **Mendez**. Well, actually, sometimes I do. We just recently had a—well, during the winter it's very cold, this winter in Denver, and we all came down with ear infections. We all came down. I had a terrible headache that made me miss two days at this temporary job that I had. And I know the baby had a slight ear infection, and one of the others, my little daughter Luana had one. We basically had to give them over-the-counter prescriptions.

And it feels very painful to see that, but we had really no extra money to take them.

The **Chairman**. Let me just ask a final question for the panel. What does it mean when you don't have—we all pointed out the debts from hospitalization to medical needs, but what does it mean to you sort of every day when you know you don't have health insurance? Does that worry you? Does it worry your family?

Ms. **Phillips**. Sure, it worries everyone in the household because it causes conflict because right now my husband says you don't need to be out, the weather is too damp for you to be out. And I says, well, I've got to go out. And so it causes conflicts and you're always at each other and you're always on the edge. So, it's hard, really hard.

The CHAIRMAN. Mrs. Reich.

Mrs. REICH. Like the Mendezes, when—we have a four-month-old, and she had an ear infection, and it was like, well, do we pay the phone bill or do we take the baby to the doctor? And in this case I took the baby to the doctor because she had an ear infection, and we didn't pay the phone bill. And this time they were nice about it, but next time who knows.

The CHAIRMAN. OK.

Senator Durenberger.

Senator DURENBERGER. Just an observation, Mr. Chairman, that there are so many people in America in this situation and it's hard to be representative, I know, but I think each of the witnesses ought to know that it is terrific for us to have you come here and share those experiences with us, as the chairman said, because it's sort of hard when you go home to get people to talk about those kinds of things. And I know it's not easy for you to come here and go through this.

Mr. Chairman, I would like to make just one additional point particularly for the record and for everybody here that this problem is even worse today in rural America than it is—if you can believe it—in an aggregate sense in our cities, because with the costs as high as they are, the support systems are kind of gone. There are people around there, but the hospitals and the doctors and so forth used to be able to take people in in emergencies and take care of them and so forth, and now that is very, very difficult to accomplish.

The technology problem, you've got to go a long way in the western part of this country, you've got to go a long way in the rural parts of this country to get that ear, if it is a serious ear problem, to get it accurately diagnosed and treated.

And so there are other dimensions here to the whole issue of financial access that you raise with your bill.There are other, very, very important dimensions here that it is difficult alone for these three people in the limited time they have to reflect for all of us. But there are a lot of Americans out there, probably more than 37 million, who need us to deal with the problems that the chairman's bill raises.

The CHAIRMAN. OK.

Thank you very, very much. We really appreciate your being here.

Our last panel: Barbara Matula, who is the American Public Welfare Association Task Force on Access to Health Care; David Ramsey, secretary of health and hospitals, from Louisiana, representing the National Association of Public Hospitals; Sterling Tucker, chairman-elect of the board of directors, American Diabetes Association; and John Polk, executive director for the Council of Smaller Enterprises.

Ms. Matula, we thank you very much for coming here. We thank all of our panel. We appreciate very much your patience.

STATEMENTS OF BARBARA MATULA, CHAIR, AMERICAN PUBLIC WELFARE ASSOCIATION TASK FORCE ON ACCESS TO HEALTH CARE, RALEIGH, NC; ACCOMPANIED BY DAVID RAMSEY, SECRETARY ON HEALTH AND HOSPITALS, STATE OF LOUISIANA, REPRESENTING THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS, BATON ROUGE, LA; STERLING TUCKER, CHAIRMAN-ELECT OF THE BOARD OF DIRECTORS OF THE AMERICAN DIABETES ASSOCIATION, WASHINGTON, DC; AND JOHN POLK, EXECUTIVE DIRECTOR FOR COUNCIL OF SMALLER ENTERPRISES, CLEVELAND, OH

Ms. Matula. We have all submitted written testimony. I will try to make this brief. I know the hour is getting late.

I chair the Access to Health Care Task Force of the American Public Welfare Association. Our work began about two years ago, and it began on a rather narrow focus. Following APWA's work with the One Child in Four, the National Welfare Reform study, we wanted to ensure that we removed disincentives for welfare families to go to the workplace and remain there. And one of those major disincentives, we found, was the loss of Medicaid benefits for very vulnerable population.

So, initially we began looking at how we could extend those Medicaid benefits to those families who were making the transition from welfare to work and in fact making a transition, we thought, to independence, economic independence and self-sufficiency.

What we found, however, was once they got into the mainstream, it was a bit muddy. We would have a situation that, while we remedied it to a degree by allowing through legislation last year, allowing Medicaid benefits to continue for one year, the gross inequity existed that folks working side by side with our welfare-to-work applicants were indeed themselves uninsured and at risk.

So, our study then grew to include looking at all employees and their dependents, and we did in fact call for universal access to health care for all Americans.

The recommendations we made fell into two broad categories. They were both incremental because they do build on current systems, existing programs, and they are comprehensive because, as I said, they would provide financial access to health care for all of those who were currently uninsured. This includes both the employed and the unemployed.

The first part, the mandate of employee benefits. I know that "mandate" is a word that some of us choke on a little bit. It may not politically be palatable but in a policy sense it makes infinite sense.

We do recommend the expansion of employer-sponsored health insurance for all employed individuals and their families. These insurance plans, much like yours, in our report would offer basic primary and acute-care services, allowing all Americans to access care on a timely basis.

We, too, recommended the establishment of either State or regional insurance pools to enable small business to purchase coverage at lower costs.

We also support equal tax treatment of the cost of such plans for the self-employed, something which your bill addresses.

Like the basic health benefits bill, we believe individuals should contribute to the cost of coverage in relation to their income. We believe that employers that do offer health insurance benefits to their workers and their families should only have to pay for it once. As it is now, employers who insure carry the additional burden of higher hospital costs to cover the costs of the uninsured. Mandated employer benefits would reduce the cost of charity care and put all employers on a level playing field. So, there is equity then not only for all employees but for all employers as well.

The second half of our task force recommendation addresses the needs of the unemployed who are also uninsured. It calls for an expanded Medicaid program with simplified eligibility for all those not covered through the workplace. While we are aware of the statistics associated with the uninsured, like the panel that preceded us, as a Medicaid director for the past ten years I can tell you that these statistics become very grim realities on a daily basis.

Today, on average, you have heard what it costs the country. Medicaid reaches out to people living at about one-half the poverty level. To illustrate this in dollars and cents and maybe to go back to the first panel and make some comparisons, the Federal poverty level last year for an individual was about $5700. The eligibility cutoff in North Carolina for Medicaid was $2900. Before that individual could qualify for help with medical expenses, he or she would have to incur $2800 in medical bills.

For a family of four, the situation is worse. Our annual income cutoff for Medicaid eligibility is $4700 compared with the $11,600 needed to sustain a family of four at the recognized poverty level, a difference of almost $7000.

What we are saying here—and when we talk about catastrophic costs, I think previous bills have used ten percent of income or 15 percent of income, surely 20 percent of income as a cutoff for what is catastrophic; that is, income that must be spent for health care—we are telling the poorest of this Nation's poor to spend more than 50 percent of an already low income on health care before they can qualify for benefits.

And then there are some individuals and families' family members who will never qualify for Medicaid no matter how poor, no matter how high their bills. These include any adults under age 65 who do not meet the social security definition of disability and who are not caretakers of a dependent child or pregnant. Those categorical restrictions prevent many single persons and childless couples and the chronically ill but not disabled Americans from ever accessing Medicaid benefits, again regardless of how poor they are.

The recent expansions of Medicaid to more poor pregnant women and young children, which the Senator has played such an important role in, are a major step in the right direction, but they are just a nightmare in determining eligibility in a large family.

For once, we have, in the SOBRA legislation for pregnant women and infants, broken the link with welfare programs for health care. But it still is a narrow window, and three months after the birth of that baby the mother no longer qualifies for even routine primary care. Depending on their ages, other children in that tiny family may not qualify for care unless they meet the spend-down requirements that I just described.

So, therefore, our Access to Health Care Task Force, much like your bill, recommends that basic health benefits be made available to all the unemployed through an expanded, and I underline, simplified Medicaid program. For the near-poor, we believe, as you do and as reflected in your bill, that individuals should contribute to the cost of their coverage but in relation to their income.

Finally, the important thing I guess we would all want to talk about is what is the cost of these expansions, can we afford to insure all Americans with a basic package of health care benefits?

I think that the question must be asked: Can we afford not to?

Those without insurance who do not qualify for Medicaid have actually become a tremendous financial burden for our public hospitals, for our not-for-profit hospitals, for Government at all levels, Federal, State, and local; and for the insured as well. Illnesses that could have been prevented, disabilities that could have been avoided, high-cost neonatal intensive care that we have spent our dollars on rather than affordable well-baby visits, these are some of the prices that we pay for failure to assure access to care for all Americans.

Cost shifting, cross subsidies, and a patchwork of Government subsidies are not much of a legacy.

Our recommendations, and I think your basic health benefits bill, build on the tradition of employer-based benefits. They build on the partnership between the public and private sectors which is so necessary if we are going to achieve this goal. Government alone simply can't afford to do it all.

Your plan and ours assures equitable treatment for all workers and equitable treatment for all employers. It provides work incentives for those struggling to achieve financial independence. It builds on systems that are in place. It encourages efficient managed-care delivery systems. And it represents, most importantly, an investment in our children and our young workers and in all Americans—and I would add, it is long overdue.

Thank you for inviting me.

The Chairman. Thank you very much.

[The prepared statement of Ms. Matula follows:]

PREPARED STATEMENT OF BARBARA MATULA

Mr. Chairman, members of the Committee, may name is Barbara Matula and I am the Medicaid-Director in North Carolina. I am here today as the Chair of the American Public Welfare Association (APWA) Access to Health Care Task Force.

APWA is a 59-year-old non-profit, bipartisan organization representing the 50 state human service departments, 800 local public welfare agencies and 6,000 individuals nationwide. APWA advocates sound, effective, and compassionate social welfare policy at the national, state, and local levels, and brings state policy leadership into national decision-making, as demonstrated during the 100th Congress in debate on welfare reform legislation.

I would like to thank you for the opportunity to testify today and to commend Senator Kennedy and the Committee for your efforts to address the needs of the uninsured.

We are all well aware of the statistics associated with the uninsured. As a Medicaid director, these statistics hit home for me on a daily basis. Although Medicaid is designed as a health care financing program for the poor, it actually can assist only the very poorest. The program, as currently designed, cannot meet the needs of all the poor and near poor. Given the current eligibility requirements, it cannot begin to help all the working poor and uninsured.

Because Medicaid cannot address the needs of all the uninsured, that responsibility is shifted onto the larger health care delivery system. Most of our large public hospitals and other health care institutions are struggling to survive under the demands of care of the medically indigent. Many hospitals find they cannot survive unless they take steps to limit access to the services used most frequently by the uninsured. As more people fall through the cracks in the current financing and delivery system, it becomes clearer than ever before that action must be taken to address the problem.

THE APWA ACCESS TO HEALTH CARE TASK FORCE

In January 1986, human service commissioners undertook a major review of public commitments to the nation's poor, a review demanded by the devastating statistics on childhood poverty. In November 1986, we released One Child in Four, a proposal for comprehensive reform of the nation's welfare system. By strengthening families and promoting self-sufficiency, we believe that poverty can be substantially reduced among American children and families.

The 100th Congress has taken the first steps toward comprehensive welfare reform, changing what has traditionally been an income maintenance program into a system that promotes individual and family self-sufficiency.

In One Child in Four we said that other efforts would be needed, including new national policies to assure access to health care for all Americans. The American Public Welfare Association's Matter of Commitment Steering Committee established the Access to Health Care Task Force to study this issue.

Human service administrators understand the links between poverty, welfare, and access to health care. Today poor families seeking to leave the welfare rolls for employment face a disincentive in the eventual loss of Medicaid benefits. While the Medicaid transition provisions of the Family Support Act begin to bridge that gap in coverage for this population by providing 12 months of medical assistance for former welfare families, there is still much that remains to be done.

Because many former AFDC families leave public programs for low wage employment that frequently does not provide workplace insurance coverage, the Family Support Act's 12 month extension of medical assistance is only a partial solution. Such families cannot secure employer-sponsored insurance as they enter the workforce, nor can they afford to purchase coverage from the low wages they earn. Many former recipients are forced to leave their jobs and return to welfare in order to meet the health care needs of their children.

In addition, there is the much larger population of the uninsured, unrelated to AFDC, who are employed but do not have access to workplace coverage and are without the adequate financial means to provide for such coverage individually.

Though it is commonly believed that most of those without insurance are unemployed, that is not the case. In actual numbers, and as a percentage of the workforce, the number of workers without health insurance is increasing. In 1985 almost 75 percent of the uninsured were either employed, or dependents of wage earners. From 1982 to 1985 the number of workers without insurance rose from 13.9 million to 17 million, an increase of 22.5 percent.

APWA RECOMMENDATIONS

The APWA Task Force saw it as our responsibility to propose alternatives so that families do not face the stark choice between taking a low-wage job without insurance and remaining on welfare in order to secure Medicaid benefits for their children. We also believe policies must assure that workers are not reduced to economic dependence by their lack of health insurance.

We concluded that the most expeditious way to deal with the problem of the uninsured is to build upon the existing systems of coverage--workplace plans and the Medicaid program. In this manner, all those who currently lack affordable insurance can be insured. Last November we published our recommendations in the report entitled Access, which members of the Committee received.

We are very pleased to see that the Kennedy Basic Health Benefits proposal acknowledges that any one single approach will not address the needs of all the uninsured. The Kennedy plan and the APWA proposal call for mandated employer sponsored health insurance and an expanded public program to provide coverage for all those not covered through the workplace.

Employer Sponsored Coverage

APWA recommends employer-sponsored health insurance for all employed individuals and their families, with a basic package to include hospital and physician services; prenatal, well-baby and well-child care; and diagnostic and screening tests. For small businesses, coverage would be provided through regional insurance pools offering premium rates equal to those available to large firms.

APWA believes that the private sector has a responsibility to provide health care coverage for its workers. This is a cost that government and the public health care delivery system can no longer afford to shoulder without the full and direct assistance of the private sector. Consumer cross-subsidy of the costs of care for the working uninsured is fast becoming an untenable proposition within an increasingly competitive health care system that is, of necessity, ever more focused on cost-containment. In addition, given the large federal deficit and growing state fiscal problems, government at all levels cannot afford to provide the necessary coverage for all the working uninsured, either directly or indirectly.

APWA therefore supports the concept contained in the Kennedy proposal of mandated workplace coverage. Further, state human service administrators believe that government should subsidize the insurance costs of small businesses that may not be able to sustain such costs without assistance.

The APWA proposal calls for mandated workplace coverage for all workers, not just those who are fortunate enough to work more than 17.5 hours per week. We are concerned that employers may reduce the number of employee hours worked in order to avoid the mandate. Further, it seems that such limitations on any mandate will only result in continued indirect, but significant, government subsidy of private sector costs of care through the expanded public program. APWA believes it is ultimately more efficient and effective for government to subsidize the costs to employers of such coverage, rather than provide payment of full insurance costs through a public program.

Expanded Public Program

We recommend a restructured Medicaid program to cover all nonworking individuals and families. The benefits would be the same as the basic employee package. We recommend that poor individuals and families could enroll at no cost, while near poor families would pay on an income related sliding scale. All other nonworking eligibles would pay full premium costs.

The APWA proposal and the Minimum Health Benefits bill assume that individuals should contribute to the cost of coverage in relation to their income, so that the program can be made available to all the remaining uninsured regardless of their income.

This approach of individuals contributing to their coverage will overcome one of the basic problems with the current Medicaid program--that it is available to only the poorest of the poor and that there is no buy-in mechanism for people of means who nonetheless have no access to insurance either because they are considered 'uninsurable' by underwriters or because they cannot afford the very high cost of an individual, non-group, policy.

We concluded early in our discussions that to meet different needs, we must pursue different policies, and these two proposals meet the varied needs. They would permit and promote effective administration because they are based essentially on existing programs and services. They also take into account the current broad consensus that employers have a responsibility to provide coverage to workers--indeed if all employers provided insurance, the number of uninsured Americans would decline substantially.

The intent of the recommendation on employer mandates is to provide universal coverage for workers and their families. For workers who earn below 200 percent of poverty, we recommend that the worker's share of the premium be subsidized by the government on a sliding scale. We view this sharing of responsibility among the employee, the employer, and the government, as a public-private partnership. Similarly, establishing state or regional pools, with public oversight or administration reflects the need for public-private partnerships to meet our health care needs.

CONCLUSION

APWA has historically supported breaking the link between cash welfare programs and Medicaid eligibility. State human service administrators have been pleased to see the progress made in expanding program flexibility to cover pregnant women and infants, regardless of their eligibility for other public assistance programs.

Ultimately, however, the country needs a broader view of health care financing and service delivery. With the growing numbers of uninsured workers it is increasingly clear that incremental expansion of Medicaid coverage and eligibility will not solve the access problems for all the uninsured. The problem of financial access to health care is not exclusively a problem of only the otherwise indigent, and cannot be treated as such. Government alone cannot, however afford to provide coverage, through a public program, to all the working uninsured. Even if government funds were available to provide coverage for all the working uninsured, this would not be sound public policy because it might undermine existing employer sponsored coverage and undercut the private insurance market.

Together, the public and private sectors can begin to address the problem. Employer mandated insurance, with the private sector providing for its fair share, and a broader role for Medicaid, are the only viable solutions to the crisis within the parameters of the existing systems.

APWA believes we must begin to look beyond segmented, incremental expansions of the current public programs and move toward broad reform of the health care financing system. Building a system that can provide universal access to health care will require the participation of both the government and the private sector.

Thank you.

The CHAIRMAN. Mr. Ramsey.

STATEMENT OF DAVID RAMSEY

Mr. RAMSEY. Mr. Chairman, I am David Ramsey, secretary of the department of health and hospitals for the State of Louisiana. In that capacity I oversee the indigent health care delivery system for the State of Louisiana, which includes inpatient and outpatient acute hospital services, inpatient and outpatient psychiatric care, the Medicaid program for the State of Louisiana, and the public health department.

I am testifying today on behalf of the National Association of Public Hospitals. The National Association of Public Hospitals consists of over 85 public and nonprofit hospitals that serve as major referral centers, teaching hospitals, and hospitals of last resort for the poor in most of our Nation's largest metropolitan areas.

I am pleased to have this opportunity to testify today on the impact that the Basic Health Benefits for All Americans Act will have on the Nation's medically indigent and the important safety net hospitals which care for them.

It is the open door for the medically disenfranchised that separate these hospitals from others. These hospitals provide a significantly higher volume of inpatient and outpatient services than their private sector counterparts and provide specialized services such as trauma care, neonatal intensive care units, burn units, and psychiatric care to the indigent and uninsured.

Patients must wait weeks for clinic appointments. Emergency rooms are overcrowded, and critically ill patients wait hours for an inpatient bed. In effect, these hospitals are serving as our national health insurance by default.

As you debate this legislation, there is debate taking place on potential new reductions in Medicare, Medicaid, and other Federal funding sources, while hard-pressed State and local Governments are struggling simply to maintain their current level of support or, as in my State of Louisiana, are actually reducing that support.

The Louisiana charity hospital system is a network of ten hospitals geographically distributed around the State. Our charity hospital system is completely State-administered. Local Governments have virtually no obligation for indigent health care. Like many governmentally supported hospitals, we are experiencing increased demand and decreased funding.

In 1986, the State spent—State funds—$243 million to support the charity hospital system. In 1989, the State spends $187 million to support these hospitals. We recently, just this weekend, attempted to change our tax structure in the State of Louisiana in an effort to move forward in a progressive way. Unfortunately, the people of our State voted this tax change down and, therefore, some of our hopes in terms of modifying our system and supporting our indigent health care system also were turned down at that point.

How will this Basic Benefits for All Americans Act affect Louisiana? It is estimated that 22 percent of Louisiana's population is uninsured. The number of medically indigent is increasing as a result of the high cost of insurance and our State's high unemployment rate. In addition, Louisiana ranks second among the States in the percentage of population living below the Federal poverty limit.

The first phase of the public program of the Basic Health Benefits for All Americans Act alone would make a dramatic difference in Louisiana. The income eligibility threshold for the AFDC Medicaid is only 23.5 percent of the poverty level. A family with an income of 24 percent of the Federal poverty level is too rich to receive Medicaid in the State of Louisiana.

The National Association of Public Hospitals welcomes the strides made by the Basic Health Benefits for All Americans Act. Particularly commendable is the recognition that the problems of the medically indigent must be addressed on both the public and private fronts.

The National Association of Public Hospitals applauds the recognition of the fact that prenatal care and well-baby care saves lives, human potential, and reaps monetary savings. The catastrophic expenditure cap of $3000 will save the already poor from utter impoverishment.

The elimination of preexisting conditions is another component of the bill tailored to the special needs of this population.

The National Association of Public Hospitals urges the small-business community to recognize the advantage of economies of scale which the aggregation of small employers and the mandated use of community ratings will guarantee. The employer-mandated aspects of this legislation will not only help the safety net hospitals to continue to provide much-needed services but should also stabilize private hospitals' budgets by increasing the percentage of services which are reimbursed. This increase in insured patients decreases bad debt and thus reduce the cost shifting now absorbed by private insurers.

We applaud Chairman Kennedy and your cosponsors for introducing legislation to address these critical concerns, and we urge you to pay careful attention to the impact of your actions on safety net hospitals in the forthcoming budget debate. Until this legislation is passed, our Nation's safety net hospitals will continue to strain under the pressures of 37 million uninsured, AIDS, trauma care, decreasing Federal, State, and local funding, and will continue to need your active support to hold together America's medical safety net.

Thank you.

The Chairman. Thank you very much.

[The prepared statement of Mr. Ramsey follows:]

PREPARED STATEMENT OF DAVID RAMSEY

Mr. Chariman, Members of the Committee, I am David Ramsey, Secretary of the Department of Health and Hospitals of the State of Louisiana. In that capacity, I oversee the indigent health care delivery system for the State of Louisiana, which includes inpatient and outpatient hospital services, inpatient and outpatient psychiatric care, the Medicaid program, and public health. I am testifying today on behalf of the National Association of Public Hospitals (NAPH). NAPH consists of over 85 public and non-profit hospitals that serve as major referral centers, teaching hospitals, and hospitals of last resort for the poor in most of our nation's largest metropolitan areas.

I am pleased to have this opportunity to testify on the impact of the Basic Health Benefits for All Americans Act on the situation of our nation's medically indigent and the important "safety net" hospitals which care for them. This legislation would make vital headway toward alleviating many of the current crises in care delivery:

- 37 million Americans are uninsured, and another 60 million are under insured.

- In the public hospitals which care for these Americans, occupancy rates continue to rise, topping 100% in some cities; emergency rooms are overcrowded to the breaking point, and critically ill patients wait up to 36 hours for an inpatient bed.

- Drug abuse, gang violence, AIDS, the homeless, refugees and other problems new in the 1980s are growing at an alarming rate in some cities -- greatly compromising and in some cases even crowding out their ability to serve less seriously ill indigent patients.

- And even as you debate potential new reductions in Medicare, Medicaid and other federal funding sources, many hard-pressed state and local governments are struggling simply to maintain their current level of support, or -- as in my own state of Lousiana -- are actually reducing that support.

It is very encouraging, Mr. Chairman, that we are once again publicly debating ways to close the enormous gaps that leave over 37 million Americans without insurance, and another 60 million with insurance that is inadequate. Until that occurs, however, it is important that you appreciate that there are just a small handful of "safety net" hospitals that are carrying the majority of this burden -- that are serving, in effect, as our national health insurance by default. And these hospitals will continue to need your active and aggressive support this year, even as you debate measures which will relieve much of the pressure.

Mr. Chairman, you and your cosponsors have been well aware of the importance of these safety net hospitals, as evidenced by your consistent support for the disproportionate share hospital adjustment, your concern about the adequacy of Medicaid as well as Medicare payment rates, and your attention to the trauma care crisis. On behalf of all NAPH members and other hospitals serving the poor, I would like to commend these efforts, to urge your continued attention to their needs during your forthcoming budget deliberations, and to offer our active support for the Basic Health Benefits for All Americans Act.

In the remainder of my testimony this morning, I would like to provide you with some detailed current information in several of the areas outlined above, by way of support for your efforts to protect our nation's indigent, uninsured, and the safety net hospitals which serve them.

First, I will describe some of the essential characteristics of our nation's medically indigent population: their numbers, their location, and the nature of the health services they use.

Second, I will describe in greater detail the current situation of major, metropolitan area safety net hospitals nationally, which provide care to this population. In this section, I will also describe the disproportionate impact on such hospitals of current health industry problems, and will discuss current sources of financing for the essential services provided by these hospitals.

Third, I will illustrate by reference to my own state the need for this bill, and for continued support of these safety net hospitals. In particular, I will describe in detail for you the present situation in Louisiana and the Louisiana Charity Hospital System.

I. Our Nation's Medically Indigent

Thirty-seven million Americans have no health insurance coverage, and another 60 million have insurance inadequate to cover their needs. While the overall estimate is clearly too high for a civilized nation, we should also look at the more detailed picture of the various subgroups among America's medically disenfranchised.

Consider the following statistics:

- ° While less than 1% of Americans over 65 are uninsured, 16.6% of children under 5, 17% of children aged 5 to 18, and 30% of persons aged 19 to 24 are uninsured. These are the three highest proportions of uninsured persons by age groups.

- ° Only 12% of whites are uninsured, but 22% of all blacks and 31.5% of all Hispanics have no health insurance.

- ° Only 11% of married persons are uninsured, but 25% of single/never married and separated individuals lack insurance (21% for divorced persons).

- ° Males are 16% more likely than females to be uninsured (16.6% of all males vs. 14.3% of all females).

- ° 550,000 pregnant women each year are not covered at the time of the delivery. About 250,000 elderly people are potentially not eligible for Medicare, for several reasons. 79 percent of these individuals live below the poverty line.

- Regional variations are also extremely significant. Only 11% of the population in the Northeast and North Central U.S. are uninsured, as compared with 19% of the population in the South and West. A Southerner is therefore 75% more likely than a Northerner to be uninsured in this country.

The vast majority of uninsured people have some link to the labor force -- only 13.4% lack such a connection. The problem is, the employed uninsured defy simple categorization. They are typically low salaried individuals, work for small businesses or unincorporated firms, or certain industries such as retailing, transportation, service industries -- and yes, health care. Over 2 million uninsured children are dependents of insured workers. Employers covered 1.2 million fewer children in 1985 than in 1982.

It will come as no surprise that most studies indicate that the health services that uninsured individuals are most likely to use are those which cannot be put off. Obstetrics and trauma head the list. A 1981 study found that obstetrical patients accounted for 45% of all uninsured hospital inpatients and 28% of all uncompensated inpatient charges. A California study found that just five diagnoses (primarily obstetrics, neonatal, and trauma) accounted for over 70% of all uninsured inpatients. The minimum benefits package in this bill is well designed to cover these crucial services.

Uninsured patients also use a tremendous volume of hospital outpatient services, and (where they exist) community health centers. One hundred percent (100%) of NAPH hospitals provide organized outpatient services, while the community hospital average is 69%. These facilities in effect are the family doctors for many uninsured patients -- indicating a considerable shortfall in effort among private physicians. This is borne out by a number of studies. For example, in Arizona, before that state adopted a Medicaid program, poor children were 40% less likely to see a physician, and poor rural residents of all ages 20% less likely, than in states with Medicaid programs.

Uncompensated medical and surgical services tend to be weighted toward emergencies or unavoidable illnesses such as appendectomies, heart failure, or advanced cancers of various kinds. Even in these cases, the services received can differ from those received by insured patients. While the current system does not meet all of the needs of the uninsured (especially for preventive care) and does not meet them in a particularly logical or uniform fashion, it is a system that does fill in many of the gaps -- at least where the institutional public hospital safety net is in place.

II. The Situation of Urban Public Hospitals Nationally

Increased attention has been paid in recent years to the valuable hospital network that serves as the safety net for America's health system. This network is comprised of a surprisingly small group of large teaching hospitals in our nation's metropolitan areas -- perhaps no more than two or three hundred in all, out of over 6,000 hospitals nationally. While there are a number of non-profit teaching and community hospitals within this network, the majority are government-supported facilities. These include city and county hospitals, state university hospitals, and hospital districts and authorities, in addition to non-profit facilities.

While these safety net hospitals operate under a variety of legal structures, they share a common mission and many common characteristics that set them apart from other community hospitals. These hospitals provide a significantly higher volume of inpatient and outpatient services than their private sector counterparts; they have seen increases in occupancy rates while the hospital industry in general has seen occupancy rates fall; they provide many unprofitable specialized services; and they are major educators of our nation's physicians and nurses. They are funded to a much greater degree than other hospitals by governmental sources (local, state and federal), and typically have a much lower proportion of privately insured patients. They continue to bear an enormous and increasing share of the burden for care to the poor in comparison to other segments of the hospital industry.

A. Care To the Uninsured and Underinsured

Although all of the characteristics I will outline below distinguish safety net hospitals from other health care providers, it is their open doors for the medically disenfranchised that truly separate these hospitals from others, and which make them particularly vulnerable to federal and state health policy (and budget reductions). The financial and programmatic situations of these hospitals have been affected by several factors, including increases in the medically needy population, decreases in Medicare coverage of costs, and declines in Medicaid coverage.

In 1985, NAPH hospitals averaged 167,184 inpatient days per hospital, of which 42,877, or 25.65%, were considered bad debt/charity care. By 1987, bad debt/charity care represented over 28% of patient days (an average of 51,788 uncompensated days out of 180,052 total days per hospital). On the outpatient side, NAPH hospitals averaged 278,463 visits per hospital in 1987, of which 116,136, or 42%, were bad debt/charity care visits.

For some individual hospitals, the percentages of bad debt and charity care were much higher. For the Harris County Hospital District, in Houston, Texas, for example, bad debt/charity care represented 79% of all inpatient days and 79% of all outpatient visits in 1987. Parkland Memorial Hospital in Dallas reports that bad debt/charity care accounted for 47% of inpatient days and 44% of outpatient visits in 1987.

The following information describes a few distinguishing characteristics of these safety net hospitals, drawing on data from our as yet incomplete 1988 NAPH survey. While this data relates only to NAPH member hospitals, we believe our sample is sufficiently large (approximately 50 hospitals responding to our surveys, with gross revenues in excess of $6 billion) to enable you to draw some conclusions about this segment of the industry as a whole.

Volume of Services. Although NAPH member hospitals are few in number, they provide a huge volume of care, and that volume continues to increase. In 1986, NAPH hospitals averaged 19,050 admissions per hospital, while other short-term acute care hospitals in the same metropolitan areas averaged only 7,038 admissions per hospital. By 1987, NAPH hospitals were averaging 19,249 admissions per hospital. Member hospitals averaged 3,873 births per hospital in 1986, while other short-term hospitals averaged just 763 per hospital. NAPH members also provided a disproportionate share of outpatient services, averaging over 242,000 visits per hospital in 1986, compared with other short-term community hospitals, which averaged only 50,414 visits per hospital. By 1987, NAPH hospitals were averaging over 278,000 visits per hospital.

Occupancy Rates. Another striking difference between NAPH member hospitals and other community hospitals is illustrated by hospital occupancy rates, and by the continued increase in these rates at a time when occupancy rates in the rest of the industry have gone down. The AHA reports that occupancy rates for community hospitals have been declining, from 75% in 1975, to 69% in 1984, and 65% in 1985. In 1986, community hospitals showed a modest increase to 67% occupancy. For NAPH hospitals, however, the rates have been considerably higher and remain so. In 1984, occupancy rates for NAPH members averaged 79%, and in 1985, 80%. By 1986, occupancy rates were 83%.

Trauma Care and Other Specialized Services. In addition to providing care to the poor, NAPH hospitals also provide many specialized services that are unprofitable and, consequently, are not offered by many other hospitals in the community. For example, seventy-six percent (76%) of NAPH member hospitals are designated as trauma centers, while only 24% of other short-term acute care hospitals provide this service. Many inner-city trauma centers provide a high proportion of uncompensated care associated with gunshot-wound victims and other victims of violent crime. The cost of such treatment is high and, most often, patients have no insurance or other means to pay for it.

As you are aware, hospitals in some parts of the country are now dropping their trauma center designations and are even seeking ways to curtail their emergency room services. Seventy-four percent (74%) of NAPH members provide neonatal ICU services, as compared with only 14% of other community hospitals. The costs associated with the provision of these specialized services can be burdensome.

AIDS. NAPH member hospitals have also been at the forefront of the AIDS epidemic, treating a disproportionate share of the AIDS population, and that burden is also increasing. According to an NAPH study of the financing and care of AIDS patients in U.S. hospitals, NAPH member hospitals treated 55% of the AIDS patients included in the survey, but represented fewer than 25% of the beds. The number of AIDS inpatients in NAPH hospitals increased over 80% between 1985 and 1987. Outpatient services to AIDS patients increased nearly 60% during that time..

We have some dramatic statistics on the sources of payment for AIDS care. Only 8% of AIDS patients in 1985 were covered by private insurance. Twenty-five percent (25%) were described as "self-pay" or "other" patients, a good proxy for non-paying patients. Sixty-two percent (62%) were covered by Medicaid (pointing to the importance of that program in the financing of AIDS care). Medicare covered only a small fraction of AIDS patients -- about 1%. Preliminary data from 1987 indicate that the percent of Medicaid payments has decreased to 54%, and the self-pay/other sources of financing have increased to 33%. Private insurance represented 9% of admissions and Medicare was up very slightly to 2%.

B. Financing of Care

Sources of Revenue. Payments for the care of low-income patients, through Medicare, Medicaid and city, county, and state funds, continue to represent the major source of revenue for large urban public hospitals. In 1987, private insurance represented only 13% of gross revenues and 19% of the net revenues for NAPH hospitals. Funds for the treatment of low-income patients represented 61% of net revenues, at an average of $71.01 million per hospital ($39.65 million for Medicaid and $31.36 million for local/state funds).

As we work toward passage of the Basic Health Benefits for All American Act, we urge this Committee not to relax its support of these safety net hospitals. Medicare payments (at 18%) represent a substantial proportion of the "insured" patient population and, therefore, Medicare payment policies are extremely important to safety net hospitals. While the disproportionate share hospital adjustment has been invaluable to NAPH members, the removal of the 15% adjustment cap has not made up for the decreases in other aspects of the Medicare program.

When Medicare payments are reduced, the local governments that own public hospitals must make up the shortfall. This is becoming an ever increasing strain; many local governments simply are unable or unwilling to make up for losses in Medicare payments.

Operating Margins A very important indicator of a hospital's financial condition is its overall operating margin, or revenues over expenses. The typical NAPH hospital has had and continues to have a negative margin, a result of revenues inadequate to cover costs of care. In 1985, NAPH hospitals' average net revenues were $111.6 million. Average expenses were $118.66 million. Therefore, on average, NAPH hospitals had a deficit of $7.06 million, for a margin of -6%.

Forty-eight percent (48%) of NAPH member hospitals reported a deficit in 1985. For those hospitals with a deficit, the deficit averaged $24.48 million. By 1987, there had been a small improvement in the deficit situation among NAPH members. However, the average margin was still negative. NAPH members reported average revenues of $117.76 million per hospital and average expenses of $123.96 million. The average margin was -$6.26 million or -5%. In spite of this small improvement, however, 48% of NAPH hospitals still remained in a deficit position, and the average deficit of these hospitals was over $14 million.

III. The Situation In Louisiana

A. The Louisiana Charity Hospital System

The Louisiana Charity Hospital system began with the founding of Charity Hospital in New Orleans in 1737; the hospital came under public control in 1813. Charity Hospital at New Orleans is the cornerstone of the State's Charity Hospital system, a network of ten hospitals geographically distributed throughout the State. Our Charity Hospital system is completely state administered; local governments have virtually no obligation for indigent care.

The importance of this safety net system in our State can be illustrated with just a few statistics. In Fiscal Year 1988, at hospital intake, 40.9% of charity system patients were designated as "free care" patients. Another 25.6% of our patients were "self-pay", often a proxy for bad debt and other no-pay patients. 25% of patients were designated as Medicaid upon intake, although it was later determined that many of these had exhausted their benefits and thus were in fact free care patients. Medicare accounted for 6.7 percent of patients on intake, and private insurance accounted for only 1.8 percent of patients throughout the Charity Hosptial system.

The State general fund accounted for 52% of the revenue source for the Charity Hospital system, with Medicaid and

Medicare accounting for 30 and 12% respectively. The remaining 6% came from self-generated sources.

In large part due to our State's overwhelming economic crisis, the Louisiana legislature approaches health policy as a line item in budget negotiations. The Charity Hospital system continues to be a signficant target for budget reduction. Despite the fact that this system serves as the care provider of last resort -- indeed the only care provider -- for an increasing number of persons in the State of Louisiana, budget reductions and concommittment services reductions have followed year upon year. In short , we are experiencing increased demand and decreased funding simultaneously. Budget realities keep us from growng to meet the needs of the population we serve.

In 1986, the State devoted $242,519,912 to the Charity Hospital system. In 1989, that figure had been reduced to $187,293,892, and the Fiscal Year 1990 budget proposes further reductions to $149,140,617.

In Fiscal Year 1988 alone, those budget reductions caused the following service reductions in the Charity Hosptial system. A total of 244 beds systemwide were closed. Units closed completely range from weekend walk-in clinics to inpatient cardiac catheter labs; from urology clinics to dermatology clinics; from diabetes education to mammography services. In addition to complete closures, there were severe reductions in outpatient clinics, outreach clinics, respiratory therapy services and even surgery services at one of our hospitals.

B. Basic Benefits in Louisiana

How will the Basic Benefits for All Americans Act affect Louisiana? It is estimated that 22% of the Louisiana population is uninsured. The number of medically indigent is increasing as a result of the high cost of insurance and our State's high unemployment rate. In 1987, 12% of the Louisiana population was unemployed compared with just over 6% of the population nationally. Louisiana ranks second among the states in percent of population living below the federal poverty level -- 18.5% in 1980 -- compared with 12.4% nationwide. Although more recent statistics are not available, the economic downturn in my state likely means that this figure has grown in the intervening nine years.

Against this backdrop, you will not be surprised to learn that the health status of our population is among the poorest in the nation. Among the states, Louisiana has the worst or near worst figures for average life expectance (the lowest in the nation) infant mortality rate (seventh highest in the nation, at 11.7%) and percentge of births to teenage mothers (second highest in the nation, representing 16.8% of all births statewide). For the years 1985 through 1987, Louisiana had the second highest incidence of low birth weight babies in the United States;

two-thirds of infant deaths occur in low birth rate babies, and they are three times as likely to have cerebral palsy and seizures.

In introducing this bill to the Senate, Chairman Kennedy descibed for us the shameful fate of Coby Howard, who died perhaps unnecessarily from luekemia because he lacked the ability to pay for required care. Like all states, Louisiana has its Coby Howards. But we also have children like Shamal Jackson, who died from poverty complicated by low birth weight, poor nutrition, viral infection and homelessness. Children of all races are growing poorer. In Louisiana, children account for 51% of Medicaid recipients, but only 15% of Medicaid expenditures. If current trends are not reversed, one out of every four children in America will be poor by the year 2000.

The United States spends $2.5 billion dollars annually to care for low birth weight babies who die or end up with long term disabilities. Yet, prenatal care is not costly. Care for a normal pregnancy averages from $400 to $600 dollars. One day in a neonatal intensive care unit costs $1,000 to $1,500, and the usual stay for this high technology, costly care is 8 to 10 days.

The first phase of the public program in the Basic Health Benefits for All Americans Act alone would make a dramatic difference in Louisiana. The income eligibility threshold for AFDC/Medicaid is only 23.5% of the poverty level. This point bears repeating; a family with an income of only 24% of the Federal poverty level is "too rich" to receive Medicaid in the State of Louisiana. In 1988, Louisiana had more than 800,000 people living in poverty. In the same year, Louisiana had 432,807 total Medicaid recipients. Thus, the initial phase alone would bring basic care to over 360,000 people in Louisiana.

As you can see from these numbers, the public program would make a dramatic difference in Louisiana in another way: financial. This legislation is important for the health and well being of the people of our State, our first priority. But my enthusiasm for this bill is tempered by the economic reality in Louisiana. Where will the State's share of the match come from, when we can no longer afford to include eyeglasses in our Medicaid Program? I urge this Committee to consider how its policies translate into reality in the states as it fine-tunes the Basic Benefits plan and devises the phase-in process.

IV. Basic Health Benefits for All Americans Act

Against this background, NAPH welcomes the strides made by the Basic Health Benefits for All Americans Act. Particularly commendable is the recognition that the problem of the medically uninsured and underinsured must be attacked on both the public and private fronts. The Committees' dual approach -- recognizing that 2/3 of the uninsured are employed or are dependents of an employed person, yet also ensuring that the remaining 1/3 are not neglected -- is exemplary and compelling. A wider range of services will be available to those who at present cannot gain access to the health care system. This legislation strikes a well considered balance between multiple, often competing, constituencies: the employed and the unemployed; small business and big business; public funding and private participation.

Because the population which this bill will rescue is precisely the population now served by NAPH member hospitals, it will be impossible for me to point out how each feature of the bill's public and private plans will impact our member hopsitals in the time alloted. Let me state that we support this bill in its entirety, and take a moment to identify a few of the particularly crucial aspects.

NAPH applauds the inclusion of prenatal and well-baby care in the minimum benefits package. This investment in prevention has been shown time and time again to reap monetary savings. According to the Children's Defense Fund, every dollar invested in prenatal care can save up to $9 over a child's lifetime, $3 in infancy alone. OTA has estimated that expanded prenatal care coverage under Medicaid will result in lower annual Medicaid outlays by reducing the proportion of infants who require intensive hospital care. We urge similar recognition of the importance of preventive and primary care for adults.

The catastrophic expenditure cap of $3000 may be the feature of the benefits package which will do the most to prevent the already poor from utter impoverishment in the face of serious illness. It could have saved the life of Coby Howard, the young boy mentioned by Chairman Kennedy whose treatable leukemia caused his death while the $100,000 required for his care were being raised. As I pointed out above, the uninsured use a disproportionate share of our hospitals' high-cost services: emergency room, trauma, neo-natal ICU.

Elimination of pre-existing condition exclusion is another component of the benefits package tailored to the special need of this population, who are more likely to suffer from chronic health problems due to their lower standard of living.

On the private side, NAPH urges the small business community to recognize the advantage of economies of scale which the aggregation of small employers and the mandated use of community rating will guarantee. The employer-mandate side of this legislation should also stabilize private hospital budgets, by increasing the percentage of services delivered which are reimbursed. This increase in insured patients decreases bad debts, and thus reduces the cost-shifting now absorbed by private insurers.

The public program side of this bill is a measured approach to this country's most intractable access to care problem: the unemployed family living near or below the poverty level. The proposed program is designed to take advantage of our years of experience with the Medicaid Program's federal/state partnership. The first phase of the public program is one of the most essential measures: coverage of all persons living below the poverty level. In Louisiana, this will bring health benefits to persons now living at between 25% and 100% of poverty, and who are "too rich," for Medicaid. We applaud your goal of ensuring that all Americans have at least basic coverage by the year 2000.

Among the other important features of this benefit is the requirement that the public plan pay copayments and deductibles, for employed workers living below poverty, analagous to the Medicaid buy-in feature for the nation's low-income elderly.

V. Summary

While we acknowledge that the committee is only beginning to consider your legislative agenda for the new Congress, we believe it is important to set concrete goals early on if they are to be achieved in an era in which the budget deficit is such an overwhelming concern. We therefore reiterate our applause for Chairman Kennedy and your cosponsors for already introducing legislation to address these critical concerns. At the same time, we urge you to pay careful attention to the impact of your actions on our most vulnerable safety net hospitals in the forthcoming budget debate. Until this legislation is passed, our nation's safety net hospitals will continue to strain under the pressures discussed above -- 37 million uninsured, AIDS, trauma care, decreasing state and local subsidies -- and will continue to need your active support. Basic health benefits for all Americans by the year 2000 -- you can count on us as partners in this crucial effort. Meanwhile, we ask that you remain our partners and hold together America's medical safety net.

The CHAIRMAN. Mr. Tucker, we are glad to have you.

STATEMENT OF STERLING TUCKER

Mr. TUCKER. Mr. Chairman, Senator Durenberger.

Senator DURENBERGER. Bring that mike over closer to you.

Mr. TUCKER. All right.

My name is Sterling Tucker, and I am the chairman-elect of the board of directors of the American Diabetes Association. The American Diabetes Association of the largest voluntary health organization representing the interests of over 11 million Americans with diabetes.

Diabetes is one of the most serious diseases of our time. Its complications can lead to heart disease, kidney disease, and blindness. Ongoing medical treatment and care are critical to the management of the disease. If left untreated, diabetes can lead to death.

The American Diabetes Association is pleased to be able to participate in this hearing on the Basic Health Benefits for All Americans Act. We thank you, Senator Kennedy, for your leadership on this important issue, ensuring that all Americans have access to essential health services.

Health care remains beyond the grasp of at least 37 million Americans, and among the 37 million Americans with no health insurance are children and adults with disabilities and chronic health conditions.

The problems these Americans experience in obtaining health care are compounded by the existence of a preexisting condition such as diabetes, cancer, epilepsy, or Downs syndrome. According to Diabetes in America, eight percent of people with diabetes have no insurance, with an even greater number lacking coverage for diabetes-related health needs.

Those employed part-time, the self-employed, and employees of small businesses frequently are rejected from any private insurance coverage based on their preexisting condition. Persons who wish to purchase an individual policy find it virtually impossible to obtain any coverage based upon categorical exclusions of certain preexisting conditions.

Those persons who are accepted for an individual policy often face unaffordable premiums, sometimes at least twice the amount of the standard cost, a minimum of six to 12 months' waiting period before coverage is provided, and exclusionary riders which exclude coverage related to the preexisting condition.

Those persons who do receive health insurance through their employer often stay locked in their jobs in order to maintain access to essential health care even though the job may be substandard, it may not provide a living wage, but they have to stay there in order to maintain or have some form of access to some health care.

Our national office and our State affiliates receive calls daily from people with diabetes seeking health insurance. A mother from Missouri called last week to find coverage for her three-year-old son who has diabetes. At age three he has been declared medically uninsurable by four major health insurance carriers.

A self-employed plumber with diabetes is losing his sight as a result of complications of the disease. He has no health insurance because of rejection for a preexisting condition and will only obtain coverage at the point he is considered disabled through social security.

Diabetes has a disproportionately significant impact on minority populations. The prevalence of diabetes is 33 percent higher in the black population. Americans of Latin ancestry are almost three times more likely to develop diabetes than nonLatins. Native Americans have the highest rate of diabetes than any population in the world.

And yet it is these Americans who as a group also have disproportionately higher rates of unemployment and lower income, who often lack any kind of appropriate, adequate, ongoing health care.

The Basic Health Benefits for All Americans Act will ensure access to essential hospital and physician services and protection against catastrophic costs for all Americans. The features of the act of particular significance to persons with disabilities and chronic diseases are the provisions of well-baby care to age one, a catastrophic stop-gap loss cap of $3000, coverage of all individuals regardless of preexisting condition.

Mr. Chairman, this problem of access to essential health care goes beyond those with diabetes. Our association is part of a large coalition supporting this need, which includes 16 other disability and health organizations such as those representing people with epilepsy, multiple sclerosis, learning disabilities, and head injuries.

The Basic Health Benefits for All Americans Act is an essential step toward universal access to health care for all uninsured Americans.

I thank you, Mr. Chairman, for this opportunity to discuss the needs of people with diabetes. I would be happy to respond to any questions you may have.

[The prepared statement of Sterling Tucker follows:]

PREPARED STATEMENT OF STERLING TUCKER

Mr. Chairman and members of the Committee, my name is Sterling Tucker, Chairman-Elect of the Board of Directors of the American Diabetes Association. The American Diabetes Association is the largest voluntary health organization representing the interests of over 11 million Americans with diabetes.

Diabetes is one of the most serious diseases of our time. Its complications can lead to heart disease, kidney disease, and blindness. Ongoing medical treatment and care are critical to the management of the disease. If left untreated, diabetes can lead to death.

Need for S.768

The American Diabetes Association is pleased to be able to participate in this hearing on the "Basic Health Benefits For All Americans Act." We thank you, Senator Kennedy, for your leadership on this important issue -- ensuring that all Americans have access to essential health services.

Health care remains beyond the grasp of 37 million Americans -- one out of every six persons. Almost 60 million more lack adequate protection against catastrophic illnesses. Among the 37 million Americans with no health insurance are children and adults with disabilities and chronic health conditions. The problems these Americans experience in obtaining health care are compounded by the existence of a pre-existing condition, such as diabetes, cancer, epilepsy or Downs Syndrome. According to Diabetes in America, eight percent of people with diabetes have no insurance, with an even greater number lacking coverage for diabetes-related health needs.

Those employed part-time, the self-employed, and employees of small businesses frequently are rejected from any private insurance coverage based on their pre-existing condition.

Individuals who wish to purchase an individual policy find it virtually impossible to obtain any coverage based upon categorical exclusions of certain pre-existing conditions.

Those people who are accepted for an individual policy often face unaffordable premiums at least twice the amount of the standard cost, a minimum 6 to 12 month waiting period before coverage is provided, and/or exclusionary riders which exclude coverage related to the pre-existing condition. Finally, those persons who do receive health insurance through their employer often stay locked in their jobs in order to maintain access to essential health care.

Our National office and state affiliates receive calls daily from people with diabetes seeking health insurance. A mother from Missouri called last week to find coverage for her 3 year old son who has diabetes -- at age 3 he has been declared medically "uninsurable" by four major health insurance carriers. A self-employed plumber with diabetes is losing his sight as a result of complications of the disease. He has no health insurance because of rejection for a pre-existing condition and will only obtain coverage at the point he is considered disabled through Social Security.

Diabetes has a disproportionately significant impact on minority populations. The prevalence of diabetes is 33% higher in the Black population. Americans of Latin ancestry are almost three times more likely to develop diabetes than non-Latins. Native Americans have the highest rate of diabetes of any population in the world. And yet, it is these Americans -- who as a group also have disproportionately higher rates of unemployment and lower income -- who lack any kind of appropriate, adequate ongoing health care.

The "Basic Health Benefits For All Americans Act" would assure access to essential hospital and physician services and protection against catastrophic costs for all Americans. Features of the Act of particular significance to persons with disabilities and chronic diseases are the provision of well baby care to age one, a catastrophic stop-loss cap at $3,000 and coverage of all individuals regardless of a pre-existing condition.

The high cost of not providing for America's uninsured is now borne by local governments and hospitals through uncompensated care, hospital emergency room admissions and the complications of disease when ongoing medical care is not available. As you know, many uninsured people avoid seeking physician care, due to the cost, until their health has deteriorated to the point of needing emergency medical treatment.

Mr. Chairman, this problem of access to essential health care goes beyond those with diabetes. Our Association is part of a large coalition supporting this need, which includes 16 other disability and health organizations, such as those representing people with epilepsy, multiple sclerosis, learning disabilities, and head injuries. The "Basic Health Benefits For All Americans Act" is an essential step toward universal access to health care for all uninsured Americans. I thank you for this opportunity to discuss the needs of people with diabetes and would be happy to answer any questions.

The CHAIRMAN. Thank you. I am familiar with that preexisting condition exclusive, since my son had cancer and he can't obtain any health insurance, nor would he be able to as an individual for the rest of his life.

The CHAIRMAN. Mr. Polk.

STATEMENT OF JOHN POLK

Mr. POLK. Mr. Chairman, it is an honor to be here today. My name is John Polk. I am the executive director of the Council of Smaller Enterprises, affectionately referred to as COSE, which is the small-business division of the Greater Cleveland Growth Association, Cleveland's Chamber of Commerce.

Our members are about 8000 small companies in our local area. Among the services we offer to our members if the opportunity to participate in one of the Nation's largest proprietary group health plans for small employers. About 6000 of our 8000 member companies provide coverage to nearly 120,000 workers and dependents through plans we sponsor, and their combined premium investment will exceed $100 million this year.

We have been providing this service to our members since 1974. We think we understand the relationship between small employers and the health care market, and our experience in providing small employers with access to affordable health care coverage is the basis for our opposition to S. 768.

It is unfortunate that our opposition to this legislation will undoubtedly be misinterpreted by some as opposition to increasing the availability of health care coverage to those millions of Americans who desperately need it.

In fact, serving as an advocate for greater access to affordable for small employers and their workers has been a key element of our mission for the last 15 years. The average size of the company participating in our plan is one with seven workers and about two-thirds of the member companies in our plan have five or fewer employees, and about 30 percent of the groups entering our plans had never had group health care coverage before affiliating themselves with our organization.

Our opposition to this bill is based on our sense of what works and what doesn't in the small group health care marketplace. And our experience tells us that the type of plan outlined in S. 768 cannot work.

Now, there are many problems with this legislation, even aside from our concerns regarding the effect of mandating the purchase of coverage on the cost and the quality of employer-sponsored plans. In this short time, let me focus on one problem borne solely of our experience.

When I joined the staff of our organization in 1978, the plan we sponsored bore a very strong resemblance to that outlined in S. 768. It contained a generous schedule of benefits and first-dollar coverage. It was a community-rated, guaranteed-issue plan with no apparent cost-containment features built in. And between 1978 and 1982 the cost of that plan increased a cumulative 130 percent.

In 1983 we redesigned our plans, reorganized their design, underwriting, and administration. We made some difficult choices, but it has paid off for our members. Participation in our plans has more than doubled since 1984, and in the past five years our members' costs have increased a combined average of 13.6 percent. We anticipate an additional rate increase to take place around the first of July. We expect that that increase will be somewhere in the neighborhood of 8.0 to 8.5 percent.

It is apparent that the imposition on our plans and the design elements entailed in S. 768 would take the years of strong management tough decisions we have exercised in bring our members' costs under control and tossed them out the window. And whom will that help? I know of 120,000 Greater Clevelanders whom it won't help at all.

Addressing our Nation's mounting health care crisis, like bringing our members' costs under control, will require sound management and tough decisions. It can't be done merely by desire, by an act of will, or by force of law. It requires an honest confrontation of the underlying problems in our delivery system which result in 37 million Americans lacking adequate health coverage. It will require cooperative partnerships involving business, Government, the insurance industry, and the provider community.

S. 768 serves a high political purpose in provoking discussion of the need for creative ways to confront these complex and painful issues in ways which will enhance and not restrict the ability of the private sector to make the best use of the creative forces which are at work in the voluntary marketplace.

COSE is anxious to address those issues. Many of the uninsured are, after all, my members, small employers and unincorporated companies. But S. 768 is not the answer to these problems. Both our local organization and National Small Business United, our umbrella organization, will vigorously and vocally oppose its passage in any form whose effect would be to restrict our freedom to make the best deal we can for our members and their employees.

The **Chairman**. Thank you.

I just have one question for these first three panelists, and then a very brief one for you, Mr. Polk.

That is, for the groups that you present, what would be the impact of this bill on the constituencies that you represent, that you speak for today? What would be the impact on them should this become law?

Ms. **Matula**. My constituency, I would believe, would be the Medicaid recipients and the Medicaid applicants who are turned down because they do not qualify. It would have a significant impact on the poor, not only in North Carolina but across the country.

I would also, through an employer benefit that is expanded, remove some children from Medicaid rolls and place them more appropriately as dependents of employees now insured in the private sector and not on welfare.

The **Chairman**. Mr. Ramsey.

Mr. **Ramsey**. I am here talking on behalf of the National Association of Public Hospitals, but certainly in the State of Louisiana we operate ten public hospitals, in essence, as well as the public health system and the Medicaid program within the department I have responsibility for. So, our constituency therefore is very broad in nature.

We find ourselves on the one hand with a health care delivery system that cannot accommodate the volume of services.

On the other hand, we find ourselves with a Medicaid program that does not insure as many individuals as we would ultimately like to insure, and therefore we have a large percentage of our population, about 22 percent, that is uninsured, and that number is in excess of 800,000 people in the State of Louisiana that therefore have to depend on a State-operated system that is in terrible difficulty with regard to restriction of services and declining services because of the financial situation of the State.

So, it is a pure and simple access to health care issue in the State of Louisiana.

Mr. TUCKER. Mr. Chairman, this issue of preexisting conditions to which you made reference is really a major, major one of deep, deep concern. Not only of concern, it is a real problem. No matter what the state of one's health otherwise, the fact of a preexisting condition shuts out that opportunity of any health insurance for most of them. And it is raised all the time, not only among those of us in the American Diabetes Association, but the 16 other health organizations to which I made reference in my testimony.

If we could close that gap, that loop, it would open up many more opportunities for persons.

Also, once one is not able to get health insurance for some reason, one is often by potential employers regarded as physically unfit, often, for other forms of work for which they are very competent and very capable and very able.

But the fact of not being able to get health insurance somehow rejects one almost totally from full participation in life. Even though one's illness may not be handicapping in terms of performance, the impact of that situation creates that image. And that is often very debilitating psychologically as well as in terms of employment and other opportunities.

The CHAIRMAN. Mr. Polk, I want to commend you on the admirable job that you are doing in providing the coverage for so many small employees in the Cleveland area. I understand you are probably one of the largest businesses of this type in the country for small business.

I remember when you testified in 1987, and I quote, "Our member prices can be as high as 40 percent higher than the comparable coverage available in larger companies."

And then as I understand from your testimony, you also indicated that the entire book of business, some $50 million in premiums was circulated out among the 65 of the top insurance carriers in the country and didn't receive a single proposal.

As I understand, the COSE's had trouble getting HMO coverage as well. I admire your perseverance, but you know, one might draw at least some conclusions, given the heights of the premiums, given the fact that even with that kind of premiums available, $50 million, without any of the companies, insurance companies, being willing to take that one, the trouble that many of the smaller companies had in getting into HMO's, those smaller businesses are getting squeezed, and the idea that they are going to be the source for opening up new opportunities for coverage for our fellow citizens just isn't going to be there.

As I understand it, you have age rating and substandard rating and medical underwriting, a lot of different kinds of conditions, you know, before small businesses are even able to get on that playing field.

I don't know if you want to make any comments or have any reaction to this. But I have been impressed by the difficulties that the small businesses have and what we might look to for the future, even with an aggressive organization like yourself and having to review what you have had to do in order to get them to even get some program for health insurance. You have had to provide a pretty strict standard or otherwise you weren't going to be competitive.

It is that whole atmosphere and climate that we are facing. I don't see any changes in it. And then I see the total number of people that are working increasing without any kind of coverage.

I would be interested in your reaction to this.

Mr. POLK. Senator, there is no question but that there are factors which exist in the market which make it difficult for small employers and their workers to obtain an adequate level of health care coverage. The differential in cost between the price of group health care coverage for small employers and the cost for large, self-insured companies result from a number of factors which exist in the marketplace, State-mandated benefits being one. We estimate that that adds about 14 percent to the cost of our members' health care coverages.

Medical underwriting, that poses a significant problem of access to small groups. We are wrestling with that problem right now on our own within our own organization to try to find some means with our insurer whereby in the context of our current plans a company may provide access to traditional group health care coverage for those employees who are healthy and create within our own program some type of partially subsidized program in which we can place individuals with preexisting health conditions.

I suspect that our ability to deal with those market conditions in the voluntary marketplace as it exists would be impeded by the imposition of a very broad and costly Federal mandate on our plans.

As I said, I fear for the financial integrity of our programs, which have enjoyed fairly significant decreases in the relative impact of rising health care costs on our members if we were forced to take out things like medical underwriting, age rating, if our ability to negotiate rates and coverages with our carriers and our providers were taken away from us. And I fear that that would be one of the results of the imposition of this legislation on our members' health plan.

The CHAIRMAN. I said I was only going to ask one question, but forgive me if I could just ask one more.

Mr. Polk, you were here when Deborah Steelman spoke today. I don't know whether you want to make any comment or whether you want to submit some reactions to her testimony. Maybe that would be a better way. But you may do it either way you want to do it.

Mr. **Polk**. My only reaction or comment is that we recognize, because we wrestle with it every day, that there are some significant problems which exist in our health care delivery system and that resolution of those problems will require a very comprehensive, thoughtful, and soundly managed approach to dealing not just with problems of access to care for the poor, for the uninsurable, also including problems of access to long-term care for elderly Americans.

I believe that this new Bipartisan Commission on Comprehensive Health Care will provide us with an admirable opportunity to address the many problems we face in our delivery system in all its breadth and complexity. And until we are prepared—public sector, private sector, providers, and insurers—to deal with these problems creatively and cooperatively, approaches like this which seek to develop a partial solution to a fairly narrow segment of our population will probably be inadequate.

The **Chairman**. Senator Durenberger.

Senator **Durenberger**. Mr. Polk, as long as we are talking to you about your plan, did I hear you say that your premium increases were 13.3 percent over the last five years?

Mr. **Polk**. 1984.

Senator **Durenberger**. Can you quickly compare your benefit package with S. 768? Have you got physician services in it?

Mr. **Polk**. Yes, we sure do.

Senator **Durenberger**. Have you got hospital services?

Mr. **Polk**. Yes, sir, we sure do.

Senator **Durenberger**. Diagnostic tests?

Mr. **Polk**. Yes, sir, we sure do.

Senator **Durenberger**. Prenatal, well-baby?

Mr. **Polk**. Yes, sir.

Senator **Durenberger**. Do you have any mental health?

Mr. **Polk**. Yes, sir, we sure do. The State-mandated minimum in Ohio.

Senator **Durenberger**. You have all the State mandates from Ohio in your plan?

Mr. **Polk**. Enjoy the luxury of operating under 14 separate State mandates in the State of Ohio. [Laughter.]

Senator **Durenberger**. And do you have a major medical of any kind?

Mr. **Polk**. Yes, sir, we sure do.

Senator **Durenberger**. Or catastrophic? What is that?

Mr. **Polk**. We have 14 different plans available through half a dozen insurance carriers in our area.

Senator **Durenberger**. And what kind of deductibles are there?

Mr. **Polk**. Deductibles range from zero—in fact, our most popular plan is our richest plan. It's a first-dollar UCR coverage plan. We have $100 and $250 deductible programs as well.

Senator **Durenberger**. And co-pays for your——

Mr. **Polk**. 80-20 up to $5000.

The **Chairman**. Sounds pretty much like our program, doesn't it? [Laughter.]

Senator **Durenberger**. Your bill will work in Cleveland. Now we have to worry about the rest of the country. [Laughter.]

Mr. **Polk**. Senator, with respect, while I think our benefit packages are roughly comparable, our ability at providing those coverages to literally thousands of small companies in the Cleveland area at a price which they can afford relative to the market is due primarily to our ability aggressively to manage those programs on behalf of our members.

One of the fears, one of the other fears, that I have with respect to this legislation is that it results primarily in reinforcing what is essentially a provider-based and provider-controlled system of health care services from which customers are disenfranchised from virtually every decision except how much to pay.

Senator **Durenberger**. You are obviously doing managed care on contract or something like that, so the choice of providers is limited.

Mr. **Polk**. That is a difficult approach for a fully insured plan to undertake. But within the next two years we hope to have the flexibility in our State to develop a fully insured hospital-based——

Senator **Durenberger**. Setting prices for the docs in the hospitals?

Mr. **Polk**. We will probably be focusing on a hospital-based approach to providing these services, yes. So, we will probably involve some type of hospital capitation.

Senator **Durenberger**. Just one observation on the preexisting condition. This would be in transition. Do you have any preexisting-condition clauses in any of your member contracts?

Mr. **Polk**. We do some fundamental medical underwriting on the smallest of our contracts. Companies with ten or fewer employees are required to submit health statements on their workers. And unfortunately, right now our agreement with our carrier is such that the existence of two or more employees in a small group with preexisting health condition would probably jeopardize coverage for the entire group.

As I said, we are attempting right now to negotiate with our carrier an alternative to that to enable us to provide access to health insurance for people who need health insurance and to provide access to subsidized care for people with preexisting medical conditions.

The commodity that people are buying when they are healthy and are making an investment in anticipation of a possible event and those individuals who have preexisting medical conditions require subsidized care for conditions which they already face are slightly different commodities. And we are trying to figure out a way to fund them equitably.

Senator **Durenberger**. Sure, and I think the whole problem of the medically uninsurable and the preexisting condition, if we could ever figure out a way to deal with it, whether it's the risk pools or something else, if we could ever figure out how to deal with that one, the rest of the people would not be that expensive to insure. But it gets frustrating.

I am now working on a case for a friend who came out of Missouri whose preexisting condition, the reason for their denial by Blue Cross of Missouri, is that he acknowledged that he went through chemical dependency treatment. You know, if that word gets out across America that if you admitted to your dependence and gone through treatment and we are no longer going to insure you, I mean that is kind of an incredible situation that we face in this country.

Barbara, let me ask you a couple of questions relative to Medicaid. If we somehow or other through this bipartisan commission that the Chair and I are on get around to recommending that we remove the elderly or 65-and-older from Medicaid, I think that that is something that you would recommend. It probably would go a long way toward freeing up at the State level some of the resources that are necessary to take care of all other low-income people. Right?

Ms. MATULA. Definitely, and especially for the elderly. And, I would add, disabled long-term care costs are probably eating up 45 percent of our budgets, with intermediate care facilities for the mentally retarded coming in second only to hospital care, yet covering very few individuals.

Senator DURENBERGER. Now, if we just expand Medicaid, like all these proposals seem to deal with, it seems to me we haven't really solved—we certainly haven't solved all the access problems because if a lot of States are like mine and mine is supposed to be one of the liberal States that is always doing good things for people—the big problem is the inadequacy of the reimbursement.

When the State gets into the time when it's facing budget pressures, the poor are the first to get squeezed. And they are fewer in number, and the little kids and people like that get squeezed before anybody else. So, if you look at Medicaid reimbursements to doctors and hospitals in my State, it continues to go down and it's getting pretty close to costs. I mean it passed charges a long time ago on its way down, and now in a lot of areas it gets very close to cost.

And the problem there is, you know, largely again that is a problem experienced first in rural areas because the doc say to heck with it, I'm leaving, and the hospitals start closing up because there are a lot of older as well as poor people out there that they serve.

So, I guess if I am right in saying that, maybe just to affirm it on the record, that in addition to following this notion that we can pick up more of the low-income people by expanding Medicaid in some way, that doesn't solve the whole problem, we still have to deal with the issue of payments to providers. Is that not correct?

Ms. MATULA. That's right. And as you know from our work on the infant mortality commission, States have at least come to grips in that area or are trying to by dramatically increasing the amount that they will pay to ob/gyn's to deliver babies, and not doing very well, in fact, in getting participation.

I think the physician problem of being below charges, I would venture to say is worse than the hospital problem, which is bad. But I think it's worse.

The CHAIRMAN. Would the Senator yield just on that point?

Senator DURENBERGER. Surely.

The CHAIRMAN. And a lot of that, isn't it because of the insurance, malpractice insurance in ob/gyn? We are finding now, with the $400 million in support of community health care, that about $70 million is just going for the insurance malpractice, and most of it is in terms of ob/gyn.

Ms. Matula. And especially to family practitioners, their malpractice cost for delivering babies is higher than that of ob/gyn's, much worse.

The Chairman. I invite the Senator's attention, we are going to try to see if we can't get with Senator Hatch and come to grips with something in this committee or Judiciary to try to see what can be done.

Senator, could you now take the chair?

Senator Durenberger. [presiding] Senator Hatch already has a bill on that. Maybe you do too.

The last kind of question that maybe each person can address. But the idea of different approaches for different people to financial access has always bothered me a lot, and that is why I put a fair amount of effort into trying to figure out what went wrong with the competitive medical plan that we offered up as a way to do Medicare.

And we are going to have to come back to that because the idea that if you fall in a certain category, you've got to go to a certain hospital or you fall in and you run the risk of getting less than adequate health care without even knowing it because of the inadequacy of the reimbursement is very, very bothersome.

So, I have just come to the conclusion that the best way for us to help buy health care for all Americans is the way we buy it for ourselves and that is by some combination of payers paying the premium costs to a health plan and that plan would then manage the access into the system and make some decisions for me about staying well, and when I had to get a medical acute care provider I wouldn't necessarily have this freedom of choice that has existed in our country so far and which we confuse sometimes with our right to health care as our right to go to whoever we please and not even knowing whether that person is high-quality medicine.

And during the course of the discussion here this morning it keeps getting reinforced for me that if—and particularly this is at the issue of adequacy of reimbursement—if in effect we were buying a health plan or selling a health plan to the States for lower-income people and we guaranteed some minimum dollar contribution to that—and here we get into the deficits and all that sort of thing—but in effect, we would sell them a plan, whether it was a preventive plan with some add-on or whatever, or maybe it would be Senator Kennedy's minimum benefits plan. We sold that to the States and then permitted that to be implemented in some way—I don't mean sell it—we have to work that out.

Then you've got a basic plan, and then people on a sliding scale can contribute an additional amount to that premium, and where an employer is able to make a contribution, that employer could also make a contribution. And you may start with a combination of the employer contribution, the individual contribution, and then the social insurance system would come along and supplement that.

But is there anything inherently wrong in following down this track of just one health plan which is supplemented at the premium level by the insured person and the social insurance system and an employer? Am I off my rocker even thinking about that?

Ms. **Matula**. If I could make a point on behalf to the poorest of the poor, there is nothing wrong with that idea, provided we have a way for the poorest to access care which could never be afforded in that basic plan, be it dental care, vision care, pharmaceuticals.

If you are at 200 percent of poverty, you have a little more flexibility in spending than if you are receiving only a public assistance check. This is why we have allowed options and a little broader coverage for our public social insurance program.

Mr. **Ramsey**. If you think about it, there already is a great deal of subsidization going on in the health care delivery system.

I mean certainly in the public hospitals, the safety net hospitals, which are delivering our national health insurance at this point in time, those tax dollars going into these institutions are subsidizing those employers that don't provide insurance.

Certainly in the State of Louisiana, there is not a big incentive for employers to provide insurance to their employees, because there is a Statewide indigent health care delivery system there that it has been its role to accept these patients. Unlike some States where they are not distributed, ours is distributed fairly well.

So, there is subsidization taking place already within the system to a large extent. Certainly, the insurance, private insurance companies, have subsidized indigent health care in private hospitals forever. And as was pointed out earlier today, that has only become an issue in this era of setting health policy by budget constraints and budget decisions in the past five or ten years or so.

Mr. **Polk**. Senator, there are forms of subsidization and there probably will be always in some form or another. Much of it is indirect, much of it is hidden but it will be there. But that still doesn't mean that your point does not have a good deal of merit.

I think where there is that type of support, as long as we are sure that the kind of services are available to everybody, is also available to those who are poor and that we protect their right to access these services in every possible way.

Frequently, even though we say that we want a system going to the marketplace the same way as anyone else, we often find market conditions different or access different, service delivery different. And so I think that as long as we provide that these different situations don't maintain, there is merit to your position.

Mr. **Polk**. Senator, as you are probably very well aware, access to health care, like politics, is essentially a local phenomenon. People tend to get sick and receive services near where they live. And while I suppose there is nothing conceptually wrong with the idea of attempting to standardize some type of plan to which all Americans would have access, it is important to recognize that to the extent that even a standard plan would be offered to people subject to the forces which exist in local marketplaces.

For example, it costs about twice as much money to get sick in Cleveland, Ohio, as it does in Cincinnati, Ohio, for a number of different reasons.

The manner in which such a standard package of benefits would be funded and offered to populations within a State—for example, 54 percent of the indigent care that is rendered in the State of Ohio is rendered in Cuyahoga County, in the area immediately surrounding Cleveland. Offering those services, providing access to those services to the various uninsured populations in that community has to be done, I think, very warily and the management of those services must be conducted very cautiously in order to make certain that the design and funding of those plans are such that guaranteed access to that standard level of benefits to everybody in the future doesn't end up costing business, Government, or the institutional sector more than those sectors can bear.

Senator **Durenberger**. Well, I take it you are the only person on this panel that is opposed to S. 768. Is that right? Everybody else is for it.

I don't know what's going on in Ohio, but I know what's going on in Minnesota and lots of other places. My impression is that if we don't do something like this, we are going to waste a lot of employer dollars across this country in State-sponsored efforts to eliminate this problem.

And if I weren't already committed to doing something in the area of universal access, I would have just in the last 12 months come to the conclusion, whether it is this bill or a modification of it or something that comes out of the bipartisan commission, just like Wisconsin hung in there for a while with unemployment comp but, you know, it wasn't going to last long unless we had nationwide.

And when you get into the employment sector, you almost, or at least the way we are headed in with these high-cost items, when we start mandating, if you will, coverage, we almost have to recognize the reality that Federal policy needs to change to accommodate that, and a broader Federal policy. I mean it isn't just the idea that everybody is going to have to have the same health insurance, it's the fact that only here can we deal with the issues of the cost of the employer to provide some of that coverage.

I don't want to keep beating on my tax cap notion here, but the reality is there is $48 billion a year going to the very richest employers in the country, and self-employed people are paying for their stuff with after-tax dollars and some of your little companies are in that same boat.

So, it seems to me there are some of those things that we can only do here to enable those smaller employers to be able to afford whatever we may mandate.

Mr. **Polk**. Certainly, Senator, two weeks from now I will have the pleasure of talking before our State general assembly which has it in mind to attempt to enact a clone of the Massachusetts health plan in the State of Ohio. We will be attempting to make essentially the same arguments in opposition to that type of plan.

However, once again, as my earlier comments suggested, I think that it would be remiss of anyone to assume that our opposition to this legislation is in some way tantamount to the denial of the existence of a very complex series of problems and the need for the Federal Government with the provider community and the business community to attempt in a creative and cooperative way to address those issues.

In fact, there are several elements of S. 768 which, taken in a slightly different context, might actually take a step or two toward resolving the problem. We are much more interested in seeking solutions to the problems than we are in passing or opposing laws.

[Additional material submitted for the record follows:]

Elliot Richardson Response to Senator Hatch Questions

1. Q. Mr. Richardson, we all know there is no free lunch. How can we be sure that this bill will not mean:

- * Increased costs passed through consumers
- * Layoffs, primarily among low wage workers
- * Reduced or frozen wages, primarily for those at the lower end of the pay scale,
- * Reduction or limiting of other benefits, or
- * The Federal government limiting the choice of benefits that low income families may receive.

A. I have not conducted a detailed analysis of the economic impact of this legislation. I understand that a number of respected analysts testifying at the Committee's earlier hearings found no significant negative economic impact from the bill. When we analyzed Nixon Administration proposals that were very similar to S. 768, we also found no major negative economic impacts. Of course, health care is not free, and any proposal to provide coverage to the uninsured will have some associated costs, but the total cost of this proposal is relatively small--only three per cent of total national health care costs for the employer mandate section of the bill.

I find your comment that this bill might result in "limiting the choice of benefits that low income families may receive" curious. The fact is that low income families have no opportunity at all under the current system to have health insurance coverage if they do not qualify for Medicaid and their employer does not offer coverage.

2. Q. Mr. Richardson, there are estimates that this bill may cost $33 billion. What kind of impact will this have on the number of business failures, on job creation, and upon small businesses?

A. As I indicated in my earlier answer, we did not find significant economic impacts of this kind in our earlier proposal, and I understand that expert analyses of this bill resulted in a similar finding.

3. Q. Mr. Richardson, as a former Secretary of HEW you are an ideal person to give this Committee an estimate of how many additional people that HHS would have to hire to administer this bill?

A. Additional employment at HHS to administer this bill should be relatively small. The bill is basically administered by private insurers and employers and by state governments.

4. Q. Mr. Richardson, this bill would impact significantly on small businesses. Are you aware of any major small business support for this bill? Are you aware of any small business workers who support this bill?

A. Most workers want health insurance coverage, and most employers want to offer it. Small businesses are faced with severe problems in the current health insurance market. They pay an excessive price for the coverage they get, and they are often unable to buy health insurance at any price. That is why this bill, and our earlier proposal, require that insurers community-rate coverage and provide it on at least a state-wide basis. This kind of a system gives small businesses the benefits of economies of scale and guaranteed availability of coverage. S. 768 also provides a permanent subsidy for small businesses facing an excessive cost for providing coverage. We had a similar subsidy, but it was only for a transitional period.

5. Q. Mr. Richardson, we have all experienced the phenomenon of program growth, the proverbial "camel's nose under the tent." Don't you believe that Congress will increase the number of mandates after this bill is passed?

A. Of course, Congress always has the option of modifying the required benefit package. I would hope that future modifications would be based on a careful analysis of the benefits and the costs of any modifications. I am pleased that the bill includes a number of safeguards against careless or excessively costly modifications. The bill requires a cost-benefit analysis by the Institute of Medicine or a similar impartial body before any modifications could be made, and it also requires that benefits could not be added that were not also required benfits under the Federal-State Medicaid program, so that both Federal and State governments would share in any additional costs.

6. Q. Mr. Richardson, how would this program fit in with existing public health programs like the Indian Health Service, a major provider of health care to Native Americans, and Community Health Centers? Would you propose elimination of these and other important safety net programs that provide free care to many Americans?

A. The Indian Health Service and the Community Health Centers programs really meet two needs. First, they help finance care for those who cannot afford to pay for it. Second, and even more important, they help assure the availability of care in areas where there would not be enough hospitals or physicians without the Federal presence. If this bill is enacted, the financing function will become less important, but the care provision function will be just as critical.

7. Q. Mr. Richardson, after your review of this bill, do you see any tangible evidence that it will mean a reduced cost of insurance premiums to individuals?

A. I do not know what you mean by "tangible evidence." The bill will reduce the cost of insurance to uninsured workers, who will now be able to get coverage through an employment-based group plan. This is much less expensive than individual coverage, and, of course, the employer will share in the cost. People on the public plan will receive subsidized coverage based on their income.

8. Q. Mr. Richardson, will this bill result in a leveling of benefits to workers covered under current plans to plans that only meet the requirements of this bill?

A. No. I see no reason that putting a floor on the adequacy of insurance coverage would result in reducing existing, more expansive coverage that is provided voluntarily. The fact that we have a minimum wage law doesn't mean that all workers are paid only a minimum wage.

SUGGESTED RESPONSES TO QUESTIONS FROM SENATOR HATCH

1.Q. Ms. Steelman, will regional pools for the uninsurable reduce cost for health insurance?

A. I am skeptical about the cost savings potential for S. 768's regional pooling structure. Establishing regionwide or statewide rates breaks any relationship between the cost of a group and what that group pays in health insurance premiums. In fact, I am inclined to think that in many ways the structure may work against cost containment objectives.

For example, a broad-based risk pool program for the uninsured could actually be more costly for small business than a mandated health insurance program for all employees. A large share of the uninsured are the unemployed, who, under a mandated insurance program, would not be covered by business. The additional expense of covering those individuals, even if it were spread out over all employers, could well be more of a burden on small business than simply covering their own employees.

An arguably appropriate role for government to play in health care is one which would extend some sort of subsidy to those in need of services but, by reason of poor health, are uninsurable through conventional means. Creation of a public/private program to provide subsidized care for uninsurable individuals who have jobs would be a feasible way to approach the problem.

Such a program might theoretically reduce the cost of health insurance, if properly designed. However, the real value of such a plan would be to increase access to coverage in the small group market. Small employers whose healthy workers might currently be denied conventional insurance coverage due to the poor health of one or more workers in a small group would have an alternative; healthy workers could be insured by conventional means, and unhealthy workers could participate in a subsidized plan. Theoretically, the employer could pay the portion of these unhealthy workers' premiums which is the equivalent of what he/she paid in insurance premium for healthy workers; the balance of the cost could be born by a public, or public/private subsidy.

2.Q. Ms. Steelman, I would like to ask you the same question that I ask Mr. Richardson, about the impact of this bill. How can we be sure that this bill will not mean:

- o Increased costs passed through to consumers,
- o Layoffs, primarily among low wage earners,
- o Reduced or frozen wages, primarily for those at the lower end of the pay scale,
- o Reduction or limiting of other benefits, or
- o The Federal Government limiting the choice of benefits that low income families may receive.

A. Senator, I believe that the problems you cite are all very likely to occur if S.768 were enacted. Unlike the Congress, which deals with these issues one at a time, businesses are frightened to death about the whole range of issues before the Congress (and state legislatures) which, if enacted, would result in dramatic escalations in the cost of labor.

We must realize that businesses, especially small businesses can allocate only a fixed amount of resources to employee benefits. Health insurance does not exist in a vacuum. It costs money, and its allocation affects the allocation of other benefits (as other allocations affect health insurance). The choice is not between health insurance or greater business profits; the choice is between full health insurance and wide range of necessaary employee benefits.

Faced with significant increases in labor costs, companies have only two viable choices: raise prices or reduce labor force. Those who will be most drastically affected will be these at the bottom of the labor force: entry-level, low-skilled workers laboring at wage levels near the poverty line, and part-time workers. Employers will reduce the hours worked by part-time employees to beat the mandate threshold. They will avoid hiring additional workers to avoid excessive labor costs. And they will furlough marginal employees.

The effect of various mandates on unemployment has been widely documented. Hundreds of thousands of job losses will occur. The question is primarily one of degree.

Finally, our experience with Medicaid is a good indicator that the Federal government's primary means for dealing with excessive costs is to limit eligibility for benefits, and the reimbursement for benefits paid out of government plans. There can be no assurance that the government's options in this case would be any different.

3.Q. Ms. Steelman, this bill would impact significantly on small businesses. Are you aware of any major small business employers or workers who support this bill?

A. No. And with good reason. If the drafters of this legislation actually believed they would win the support of small businesses with their small business provisions, they are badly mistaken. This bill proposes to subsidize small businesses who spend more than five percent of their gross sales on health insurance. Any company that can afford to spend five percent of its gross sales on health insurance does not need a subsidy. Seriously, five percent of gross sales is an enormous amount of money, and it is not an amount most small businesses could afford to spend.

4.Q. Ms. Steelman, after your review of this bill, do you see any tangible evidence that it will mean a reduced cost of insurance premiums to individuals?

A. As I mentioned in response to your earlier question, the cost containment potential of this bill is low. Everthing I see in this bill, combined with everything I know about small group health insurance coverage leads me to expect that health insurance costs for individuals will rise as the result of its enactment. In fact, one might expect a relatively inflationary period during its implementation. The benefit levels are very generous, there are no built-in cost-containment features, and purchase of the benefits would be compulsory. Under the system which would result from S. 768, there would be no incentive for any player to control costs.

5.Q. Ms. Steelman, will this bill result in a leveling of benefits to workers covered under current plans to plans that only meet the requirements of this bill?

A. Conceivably, under the terms of S. 768, there would be a "levelling" of benefits received. As with so many other mandated programs, the minimum benefit required will become the maximum benefit extended. However, given that the plan outlined in the legislation is more generous than that offered by nearly two-thirds of employers to their workers, the levelling would be upward, not downward.

SUGGESTED RESPONSES TO QUESTIONS FROM SENATOR KENNEDY:

1.Q. You criticize the BHB legislation for failing to include proposals to address health care cost inflation. What cost containment measures are included in the proposal you outlined for the Committee? What proposals would you endorse?

A. No one at this point has an adequately developed answer to the health care cost problem. However, one thing is clear. A major expansion in coverage such as is envisioned in the Kennedy bill will have a significant inflationary impact. One need look only as far as the Rand experiment to conclude this. In expanding coverage we must move gradually so that adequate cost containment controls may be concomitantly designed and put in place.

However, I have provided some suggestions. The proposal assumes that private insurers would continue to implement the managed care techniques that are available and others that are being developed to insure appropriate use of medical care. These programs seek to acheive practitioner adherence to widely agreed upon medical practice standards that have been incorporated into protocols.

One cost containment technique commonly included in health benefit plans, requirements for second opinion before elective surgical procedures, avoids unnecessary procedures and, in some cases, encourages the use of more efficient alternatives. Some plans use concurrent review of in-patient hospital stays to prevent excessively long inpatient stays.

The use of some covered services, such as expensive emergency room care, is reviewed retrospectively by many plans to verify that the condition being treated actually required the service delivered. I encourage this panel to join with other members of the Senate such as Sen. Mitchell who are currently developing legislation to conduct the research necessary to develop widely agreed upon standards or medical practice. These measures should seek the active participation of medical specialities societies in the analysis and development of guidelines for the appropriate use of medical care services.

2.Q. Your written testimony endorsed extending full Medicaid coverage to all poor people, as would be done under the BHB legislation. What would the Federal or total cost be of such an expansion if no employer mandate is established, and voluntary employment-based coverage does not expand? What would the cost of such an expansion be if it only applied to those who are not employees or dependents of employees?

A. Precise estimates of the cost of expanding Medicaid require access to large scale databases such as the Census' Current Population Survey. I do not have an independent capability to access and analyze such databases, so this question is really one for the Congressional Budget Office. Review and adjustment of basic work done by others, however, suggests that the fiscal 1990 cost to the Federal budget of covering all the currently uninsured poor under Medicaid would be in the $6-$8 billion range (full-year costs assuming 100% participation among the currently uninsured poor and no shifting among those currently covered). Covering only the unemployed poor and their dependents would cost approximately half as much.

This legislation places the cost of providing a highly desirable benefit on the low income population itself and reduces the income they have to obtain other necessities. This would break a decades long commitment to provide assistance to the low-income population through public programs financed by broad-based taxes. Health benefits are simply one form of compensation and requiring employers to provide health benefits will shift compensation from wages to this mandated fringe benefit. The net effect will be lower discretionary income of these low-income workers. For these low-income workers, income may be better used to provide better diets, better housing than to provide the health care required by this bill.

3.Q. In your oral testimony, you suggested that extension of full Medicaid might not be affordable and you advocated an alternative that would extend Medicaid to "out-of-hospital primary, preventive, and ambulatory services on a first dollar basis." Would this benefit include all physician and hospital services provided on an outpatient basis, or some restricted group of such services? What preventive services would be included? What would the total cost of such a package provided to all the poor be? Please explain the basis of such an estimate and the number of people you believe would be covered.

A. A primary and preventive care package would include many, but not all, ambulatory services. The most significant exclusion would be major outpatient surgical procedures (which might be defined as any treatment or procedure that could not capably be rendered by a family practitioner or general pediatrician). Mental health services and substance abuse treatment would not be covered. Of course, no inpatient care of any sort would be covered.

Covered preventive care could include a prudent schedule of preventive health visits, including appropriate immunizations for children and a few critical tests, along with counseling/patient education onhealth risk factors. The schedule used by the INSURE Lifecycle Preventive Health Services Project, sponsored by the insurance industry, would be one possibility. The Committees may also wish to review the recommendations of the U.S. Prevention Task Force, which are due out shortly.

This package should cost only about 30% as much per person as does traditional Medicaid for a comparable population (AFDC adults and children). How many are covered depends primarily on the eligibility rules, not the benefit package, but this package was originally designed to assure access to primary care for the near-poor who have other (probably high deductible) coverage for major illnesses.

4.Q. How would the average cost of providing such a benefit to an individual or family compare to paying the average cost of co-payments and deductibles for such an individual or family under the Basic Health Benefits plan?

A. The purpose of the proposed primary care package is to assure that financial barriers do not deter near poor persons from availing themselves of preventive services. While the deductibles envisioned for the basic plan would not deter persons with higher incomes from seeking such services, they might do so for the near-poor. The proposed buy-in plan would address this problem, whatever the relationship between benefits received by a given individual and the deductible of the private insurance plan. Further, benefits paid for by Medicaid under the primary/preventive care plan should be countable toward satisfying the deductible of the basic plan, to the extent they would have been covered under the basic plan if the deductible had already been met.

The primary/preventive care package care package would have an actuarial cost (based on Medicaid expenditures) in the range of $50 - $70 per month for a family of three. (If made available as a "buy-in" for the near-poor, government costs would be reduced somewhat by sliding-scale premiums.) It would cover some benefits, such as outpatient prescription drugs and adult preventive care, that are not covered under the Basic Health Benefits plan. I do not have an estimate for the cost of paying the copayments/deductibles under the Basic Health Benefits plan. Such an estimate is complicated by the provision for actuarially equivalent plans -- it remains to be seen what cost sharing arrangement, on average, employees would face.

5.Q. If such a limited package of benefits were provided to the poor and near poor, who would pay for necessary hospitalization and other uncovered services? What protection would beneficiaries have against these costs?

A. As I noted above, the primary/preventive care package was originally designed as supplementary coverage for the near-poor, not as basic coverage for the poor. In the context of the near-poor, I would expect that many would have employer-provided insurance which would cover, probably subject to a deductible, the costs of hospitalization and any major outpatient surgey that might be needed. For those without private coverage, requiring all states to cover the "medically needy" would limit the near-poor's out-of-pocket liability for hospitalization. Providing only primary and preventive care to the poor is more difficult to justify and relies primarily on two arguments: (1) that funds are simply not available to do more, and (2) that those funds which can be made available should be used to expand the actual delivery of needed services to the poor, not simply to refinance care which is already being delivered.

Payment for necessary hospitalization for those enrolled in a package of primary care benefits would come from a variety of sources.

For those incurring substantial expense associated with in-patient hospital stays, the individual's liability would exceed the Medicaid spend-down level and the Medicaid program would begin to pay benefits. From some of the working poor, the cost of spending down to Medicaid would be relatively minor.

Payment of amounts less than the Medicaid spend down amount could be negotiated between the individual patient and the hospital. Financing could be provided by the state and/or the federal government. This approach would appropriately target public subsidies on those low-income individuals least able to pay for their own medical care.

6.Q. You contend that elimination of state mandated benefit laws would reduce the number of uninsured by 9.3 million. What is the source of this estimate? Explain, in as much detail as possible, the basis for this estimate.

A. This estimate was made by a research group in Dallas called the National Center for Policy Analysis. In this analysis, the Center used regression analysis to estimate the effect of state characteristics (level of economic activity, structure of a state's economy, indirect business taxes, and state health insurance regulations, including mandated benefits) on the percent of each attempted states non-elderly population without health insurance. The results of their analysis showed that each additional benefit mandated by a state increases the percentage points.

I would suggest that you contact the researchers directly with any detailed questions you have on their study.

7.Q. You recommend a private reinsurance mechanism for uninsurable employer groups. You say that "losses from the reinsurer would be spread equitably". What do you mean by this? Who would pay for losses and on what basis? Why should the mechanism be private? How would the determination that a group is uninsurable be made?

A. By equitably, I mean in a way that is fair and assures that coverage as well as losses incurred by the pool are affordable to the parties affected. The mechanism should be private because the marketplace is largely private. It would be necessary to assess all employers who could be reinsured through the pool (e.g. all those with 10 or fewer employees). This would include those employers who have obtained coverage through HMOs and other arrangmenets.

Determinations of the insurability of individual groups, and thus, determining which groups would be reinsured, would be made in accordance with traditional medical underwriting standards applied by insurance companies.

If the proper structure is established, the private sector would finance the costs and oversee the reinsurance mechanism, saving government the money and obligation of doing so.

8.Q. Your testimony does not mention pre-existing condition exclusion provisions characteristic of the current small employer and individual insurance market. How would you assure protection for people affected by these provisions because they buy their coverage as individuals or because they are employees of a small business? Would you support prohibition of pre-existing condition exclusions? Why or why not?

A. Individuals in small employer groups with high cost/uninsurable conditions could purchase coverage from the reinsurance mechanism. High risk individuals would be assured coverage through high risk pools.

Preexisting condition exclusions are intended to prevent individuals with known medical conditions from obtaining coverage with individuals who have no known risk factors and, thus, share the same probability of becoming ill and requiring medical care.

Permitting individuals with known conditions to enroll in insurance, on individual or small group basis, would encourage individuals to purchase coverage only when they need medical care. This behavior towards health insurance purchase would erode the risk spreading function of insurance and quickly lead to increasing health insurance premiums. Coverage would become less affordable for large numbers of individuals.

9.Q. According to Census Bureau figures, three quarters of the working uninsured are not poor, and more than 60 percent have family incomes above 100 percent of poverty. Your proposal for Medicaid expansions would not help this group. How do you recommend that they secure insurance?

A. For the highest income uninsured invidividuals, I believe that coverage should be privately purchased insurance. Approximately 40 percent of the uninsured have incomes more than two times poverty and 14 percent more than 400 percent of poverty. Individuals with significant personal income are not appropriately included in a public program.

For the other uninsured who are between poverty and 200 percent of the poverty level, changes in state mandates and other steps which I have outlined would make coverage more affordable and induce more employers to offer coverage and lead more employees to purchase it.

Non-poor workers and their dependents would be covered in most cases by employment-based insurance. The number of covered employees would be expanded by two main strategies. First, the reinsurance mechanism I discussed in my testimony would assure that coverage would be available to small employers with high risk employees at reasonable rates. Second, the ERISA preemption would allow the insurance industry to offer employers basic coverage that is more affordable.

Coverage of the self-employed would be encouraged by making their premium payments fully tax deductible. Finally, state high risk pools would make coverage available to those not insurable through other mechanisms.

10.Q. You recommend four changes to encourage expansion of private insurance coverage: elimination of state mandated benefit laws, establishment of a private reinsurance mechanism for uninsurable groups, establishment of high risk pools for uninsurable individuals, and full deductibility of health insurance premiums for the self-employed. How many additional people do you estimate would gain health insurance as a result of these four steps? Please provide separate estimates, if possible, for the uninsured members of working families and other uninsured, and for the poor and non-poor. Please explain the basis of your estimates.

A. In my statement, I indicated that one estimate places the number of uninsured today attributable to state mandated benefits to be 9.3 million. Elimination of state mandates would, thus, be expected to reduce the number of uninsured by roughly this amount. The analysis of the relationship between state mandates and insurance coverage was not done with data that permitted the identification of the work status of individuals without coverage, hence it makes it impossible to answer this question directly.

One major problem with the Current Population Survey used to analyze the uninsured for this and other proposals is that it lacks sufficient detail to answer many significant policy questions, such as the one that your question raises.

The many uncertainties related to the uninsured population only reinforces our belief that adopting mandates without a better knowledge of the policy relevant factors related to being uninsured should be well understood before proceeding with a mandate in order to guage these consequences on the uninsured.

NATIONAL
ASSOCIATION
of
COUNTIES

440 First St. NW, Washington, DC 20001
202/393-6226

May 9, 1989

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
SD-428 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Kennedy:

On behalf of the National Association of Counties, we are pleased to submit this statement for the record on the May 1, 1989 Hearing on Basic Health Benefits for all Americans, S. 768.

We would like to commend you, Senator Kennedy, for your leadership in addressing the health care needs of our nation's residents. Your commitment has ensured that attention continues to be focused on this critical issue and county governments share with you a sense of urgency regarding it. Our concerns are based on the fact that county government is dedicated to meeting the basic needs of people at the local level and county governments are responsible in increasing manner for assuring that health care is available for those most in need, the indigent who have no other form of protection or assistance for health care services.

In 18 states, county governments bear sole legal responsibility for indigent health care, in four more states they bear this responsibility if they operate hospitals, and in eight more states they share this responsibility with the state or with towns.

U.S. Census department data indicates that in 1986 counties spent $14.7 billion for hospital and health care services.

We have established a Task Force on Indigent Health Care in our efforts to address the role of county governments in this regard. The Task Force members are drawn from a number of the policy making Steering Committees of NACo and represent the variety of interests we have concerning this issue: Health, Labor and Employee Benefits, Tax and Finance, Human Services, and Intergovernmental Affairs. The recommendations generated by this group are the result of intensive discussion and deliberation.

The Task Force has met once to receive an intensive briefing on the issue of indigent care and to specifically address the provisions of the earlier version of your proposal (S. 1265). An agenda from that meeting, and a roster of Task Force members, is enclosed and we would appreciate you including these in the record with this statement. As a result of the first meeting, a resolution was generated which was then adopted by the NACo Board of Directors at its meeting during the NACo Legislative Conference in March. A copy of this resolution: "On Access to Basic Health Care Services for All Individuals" is included and we also request that it be a part of the record.

Our consideration focused on the two ways in which county governments would be affected by a proposal such as yours. The first is as a provider of health care services to the indigent, which we have clarified above. In that regard, counties would be well served by a program which offered health insurance or some form of financial assistance to those who are currently unprotected. If, indeed, the cost to counties reflected in the $14.7 billion in 1986 was generated to any extent by working persons who had no health insurance, counties would benefit as a result of increased insurance protection.

The other way in which county governments would be affected by any proposal which relied on employer provision of health insurance benefits is as an employer, often the most significant employer in a community. We are proud of the fact that counties in general provide generous health benefits for their employees. Nearly 94% of full-time employees in state and local governments are covered by health insurance.

The resolution reflects our consideration of the dual effect on county government of your proposal.

After considerable deliberation and debate, we agreed that improving access to health care services to all individuals is a matter of critical importance. As such, we agreed that basic health care services should include a specified range of benefits, including: hospital inpatient care, emergency medical services, physician services including essential prescription drugs, ambulatory care, pre-natal and well-child care, and mental health care.

In our discussion of these benefits, we drew on the fact that county governments have a unique perspective and appreciation of the value of preventive health care by virtue of the fact that such services are a critical component of the public health departments run by counties. Over 75% of the over 2000 local health departments in the country are operated by county governments. We feel that primary and preventive health care services should be emphasized, including prenatal and well-child care. These services are essential to prevent future high medical costs that result when early intervention and prevention are unavailable. We support the incentives provided for prenatal and well-baby care in your proposal by having no deductibles or co-payments for them. Likewise, we felt that a basic set of mental health benefits are a valued and commonly accepted part of health benefit plans and are necessary to allow early intervention for mental disorders and mitigate against possible later somaticization of nervous conditions.

Our next major recommendation was in support of the concept that persons who are employed should have health care coverage through their place of employment. This recognition, and the responsibility it will carry for county governments as employers, is in keeping with our earlier support for the expansion of the Medicaid program for pregnant women and children even though county governments contribute to the non-federal share of the Medicaid program in 14 states.

We have several concerns for the further refinement of this concept of employer provided health insurance. In particular, we are concerned for the small business for which such a mandate could be a severe financial hardship. We were pleased to see that S. 768 would allow a regional approach to mitigate against this hardship by allowing community rating across a broad pool of participants. We were also pleased to learn that smaller counties, which employ 30 or fewer persons, would be eligible for these regional mechanisms. We are interested in the use of other incentives such as deductibility of employer premium contributions that would continue beyond a reasonable phase-in period.

We have continuing concerns for the treatment of temporary and part-time employees. We are currently in the process of doing a survey of counties to see to what extent they provide health insurance to their workers, and to what extent health insurance is available for part-time and temporary workers. More detailed recommendations will await our examination of these data.

We have concerns for the impact of such a program on existing industry standards and practices, including collective bargaining agreements that are now in place. This is another area that we are examining in greater detail.

In sum, we look forward to working with you as you refine your proposal to address this critical issue. County governments have a history of meeting local needs at the local level. We urge your sensitivity to that role as you develop mechanisms for the federal government to assist in meeting these needs.

Sincerely,

John P. Thomas

John P. Thomas
Executive Director

HEALTH AND EDUCATION STEERING COMMITTEE RESOLUTION ON ACCESS TO BASIC HEALTH CARE SERVICES FOR ALL INDIVIDUALS

WHEREAS, thirty-seven million people in America have no health insurance and another fifty-three million are underinsured with no protection against catastrophic illness; and

WHEREAS, approximately two-thirds of the uninsured, including seven million children, are members of families in which at least one member of the household works full time; and

WHEREAS, the rising costs of medical care, combined with the increasingly competitive nature of the health care market, may result in a worsening of the medically indigent's access to needed care; and

WHEREAS, small businesses entering the insurance market endure unnecessarily high costs due to the fragmentation and inefficiency of the current system, while businesses that already insure their workers pay a higher price for the failure of other businesses to do likewise; and

WHEREAS, all counties are concerned with the general well-being of the public and many are legally responsible for general indigent health care, but at the same time are constrained by mounting insurance costs and limited resources:

THEREFORE, BE IT RESOLVED that the National Association of Counties urges Congress to enact legislation that would improve access to basic health care services for all individuals; and

BE IT FURTHER RESOLVED that the National Association of Counties urges such legislation to include the following:

° Basic benefits including hospital inpatient care; emergency medical services; physician services including essential prescription drugs; ambulatory care; prenatal and well-child care; nervous and mental health care;

° Greater emphasis on the provision of preventive and primary care, and the establishment of a payment system that results in equity across all public and private payers as well as fair payment to providers;

° Achievement of the most cost effective health care system possible for the benefit of individuals, taxpayers, employers and providers; and

BE IT FURTHER RESOLVED that the National Association of Counties supports the concept of employed persons and their dependents receiving coverage through their place of employment, provided that:

° Co-payments and deductible levels are established within reasonable existing local industry standards and practices or existing collective bargaining agreements;

° Small businesses are provided special incentives such as tax deductibility of employer premium contributions, availability of regional pools for community ratings, and phase-in period for new businesses;

° Employers may exclude working retirees who are covered by retirement-related health plans and other employees who are covered under other plans which meet the basic benefit standard and choose to waive their participation; and

BE IT FURTHER RESOLVED that the National Association of Counties urges the coverage of unemployed persons, or persons unable to acquire employer-based coverage, through a system cooperatively developed by a combination of federal, state and local effort.

Adopted by the Indigent Health Care Task Force
(unanimous)
March 3, 1989

Adopted by the Health and Education Steering Committee
(unanimous)
March 4, 1989

Adopted by the NACo Board of Directors
March 5, 1989

TASK FORCE ON INDIGENT HEALTH CARE
WASHINGTON, DC
JANUARY 26-28

AGENDA

WEDNESDAY

arrival in Washington DC

THURSDAY, JANUARY 26

8:30a.m.	Welcome & Introduction	-	John Thomas
9:00a.m.	Defining the Problem: Who Are The Medically Indigent?	-	Larry Bartlett, Ph.D. Health Systems Research, Inc. Washington, DC
10:45a.m.	Coffee Break		
11:00a.m.	Public program coverage (Medicaid)	-	Larry Bartlett
12:30p.m.	LUNCH		
1:15p.m.	State/local programs	-	Patricia Butler, J.D. Denver, Colorado
2:15p.m.	Coffee Break		
2:30p.m.	Private Sector Response	-	Patricia Butler
4:00p.m.	Discussion		

FRIDAY, JANUARY 27

9:00a.m.	Federal Legislation: Mandating Health Benefits From Employers	-	David Nexon Staff Director, U.S. Senate Committee on Labor and Human Resources

10:30a.m.	Coffee Break	
10:45a.m.	Discussion of Minimum Benefits Proposals:	
	1) Costs	Alan Fairbanks, Congressional Budget Office
	2) Opposition to Minimum Benefits Proposals	TBA
	3) Mandates as a Health Policy Mechanism	Daniel Fox, Ph.D. Health Sciences Center SUNY, Stony Brook, NY
12:15p.m.	LUNCH	
1:00p.m.	Discussion of Policy Options	
2:30p.m.	Break	
2:45p.m.	Develop Draft Recommendations	

SATURDAY, JANUARY 28

9:00a.m.	Review Draft Recommendations
10:30a.m.	Break
10:45a.m.	Discuss Plans For Finalizing Policy Recommendations
12 Noon	Adjournment

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JOHN WAIHEE
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JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
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HONOLULU, HAWAII 96801

In reply, please refer to:
File:

April 28, 1989

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
U.S. Senate
Washington, D.C. 20510

Dear Senator Kennedy:

As Director of Health for the State of Hawaii, I oversee a department that provides a wide range of public health, hospital and outpatient services to the people of the State of Hawaii. My colleague and fellow Director, Mr. Mario Ramil, is Director of the Department of Labor and Industrial Relations for the State. Together with the Director of our State's Department of Human Services, Mrs. Winona Rubin, we are engaged in a number of collaborative efforts to improve the health and human services system in Hawaii.

It is with interest that we have reviewed the provisions of S 768. We strongly support a national insurance "safety net" that S 768 proposes to enact. Our State's Prepaid Health Care Act required such coverage for more than fourteen years and has clearly shown its benefit to our people. We are thus submitting the attached testimony to register our support for S 768 and to inform your Committee about our State's programs.

We look forward to working with you and your staff as this measure continues to develop. Many thanks for your consideration.

Very truly yours,

JOHN C. LEWIN, M.D.
Director of Health

Attachment

cc: The Honorable Mario Ramil
Director of Labor and Industrial Relations

The Honorable Winona Rubin
Director of Human Services

COMMITTEE ON LABOR AND HUMAN RESOURCES
U.S. SENATE
ON
S 768
THE BASIC HEALTH BENEFITS FOR ALL AMERICAN ACT

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JOINT TESTIMONY OF
MARIO R. RAMIL
DIRECTOR
HAWAII STATE DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
AND
JOHN C. LEWIN, M.D.
DIRECTOR
HAWAII STATE DEPARTMENT OF HEALTH

TO
COMMITTEE ON LABOR AND HUMAN RESOURCES
U.S. SENATE HEARING

ON
S 768
THE BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT

As Directors of the Departments of Labor and Industrial Relations and Health for the State of Hawaii, we strongly support the major concepts outlined in the Basic Health Benefits for all Americans Act.

The bill represents a major policy decision for the federal government, a decision which has many implications for both the private sector health providers and the public sector which often provides for indigent care. Your measure recognizes an important fact, that many people in the United States have inadequate access to health care because they lack the financial resources to purchase the health insurance that provides the funding mechanism for health care services in America. The large "gap group" that exists in the United States is significant testimony to the fact that we have not adequately provided health care to all members of our society. By depriving so many Americans of adequate health care, we reveal our lack of compassion and long-term fiscal wisdom; many preventable health conditions, when not dealt with early, cost the health care system vast unnecessary resources.

We wish to state unequivocally that the basic premise behind this bill, mandated employer benefits, works. It has worked in the State of Hawaii for the last 14 years, and from Hawaii's experience, we believe that it will work for the United States as a whole.

Hawaii's Prepaid Health Care Act was passed in 1974. This Act, which requires that each employer provide health care insurance to his/her employees, is landmark legislation. This program has been made possible by its exemption from the provisions of ERISA by federal legislation. Through the Prepaid Health Care Act, Hawaii has reduced the percentage of those without health insurance from about 12% without hospital coverage and over 17% without medical coverage in 1971 to approximately 5% of our state's population in 1989. The people covered by this mandated health care insurance possess a broad comprehensive coverage that provides for adequate hospitalization and outpatient services at reasonable costs that are shared by both the employer and the employee.

While our system insures 95% of the Hawaii's population, there are gaps. These gaps consist of: 1) unemployed workers,

2) part-time employed workers under 19 hours a week, 3) workers in certain seasonable occupations, 4) spouses and children of low-income workers who elect not to choose family coverage (although there is some disagreement on the size of this population), 5) students, 6) self-employed persons and members of family businesses, and 7) real estate and insurance sales persons paid solely by commission.

Even though the gap group still exists, prepaid health care has limited its size to manageable proportions. Hawaii has addressed the gap group in legislation introduced during our 1989 legislative session and now has authorization for a preventive primary care insurance program to bridge the gap. Mandated health care benefits have made such an initiative possible and fiscally within reach.

Prepaid health care costs have not significantly impacted employers. By requiring all to provide health insurance, the law ensures a level ground for fair competition. By helping to maintain a healthy workforce, it indirectly improves productivity. Negative impacts have, however, resulted from the wording of Hawaii's ERISA exemption, which does not allow for the Act, passed in 1974, to be significantly amended. As such, the exemption prevents changes in the Act which might help employers to contain costs.

We thus appreciate the exemption allowed Hawaii in this proposal. It allows us to continue to develop methods to reach our small gap group and to share the results of these policy initiatives with the rest of the nation. We would, however, like to work with Congress to develop a flexible exemption from ERISA which would allow amendment of our present system.

We look forward to elaborating upon our proposals at your convenience. We would be most happy to provide whatever expertise we can in assisting you and your committee to enact this concept nationally.

Thank you for giving us the opportunity to present our views to your Committee. We look forward to working with you to provide adequate health coverage for all Americans.

April 28, 1989

ISSA The Experts on Cleaning and Maintenance

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May 12, 1989

Mr. David Nexon
U.S. Senate
Labor and Human Resources Committee
527 Hart Senate Office Building
Washington, D.C.

Dear Mr. Nexon:

On behalf of the International Sanitary Supply Association (ISSA), we respectfully request that our statement on S.768, Mandating Health Benefits legislation, be included as part of the official hearing records (May 1, 1989 hearing).

Thank you very much for your help and assistance on this matter.

Sincerely your,

Warren E. Stickle

Warren E. Stickle
Consultant
Legislative and
Regulatory Affairs.

ISSA is an International Association of Over 3,400 Companies Manufacturing and Distributing Cleaning and Maintenance Products.

STATEMENT

OF

MANDATORY HEALTH BENEFITS LEGISLATION

BEFORE THE

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

MAY 1 , 1989

Mr. Chairman: My name is E. Allen James, and I am President of the International Sanitary Supply Association (ISSA). We appreciate the opportunity to submit this statement as part of the official hearing record on S.768, involving Mandatory Health Benefits Legislation, which is before this Senate Labor and Human Resources Committee. We commend you and your colleagues for considering the status of employee benefits in this country, but we must object to the mandatory aspects of the bill.

ISSA is a voluntary non-profit membership association consisting of about 3400 companies, located in every state, that are engaged in the manufacture, formulation, distribution and sale of antimicrobial and general cleaning and maintenance products used in institutional and industrial establishments such as hospitals, nursing homes, schools, restaurants, hotels and food processing plants. Our products include disinfectants, sanitizers, germicides and other products utilized to protect the public health and safety. These products must be scientifically formulated and applied according to specific directions in order to effectively sanitize manmade surfaces. As such, our industry is heavily regulated by the Environmental Protection Agency and the Occupational Safety & Health Administration.

ISSA members also produce brooms, brushes, plastic bags, deodorants, floor finishes and seals, floor maintenance pads, soap, mopping equipment, rug and carpet shampoos, drain openers, and paper products such as hand towels and toilet tissue. Collectively, ISSA members manufacture, produce and distribute approximately $19 billion in goods and services.

The cleaning and maintenance industry is primarily composed of small businesses. 65% of ISSA's members have annual sales under $2 million, and over 60% employ less than 30 workers. They are formulators and distributors who sell a wide variety of low volume, low profit products. By its very nature, the industry is very competitive and labor intensive. As such, employee wages and benefits constitute a significant portion of the cost of doing business, and therefore these costs must be efficiently managed. ISSA members offer a variety of benefit packages, including health care, in order to attract and maintain key employees essential to the proper formulation of disinfectants, sanitizers and other antimicrobial products. Today companies enjoy the flexibility which allows them to create innovative benefit programs that are specifically tailored to the needs of their workforce.

ISSA is a member of the Concerned Alliance of Responsible Employers (CARE) a coalition of trade associations, corporations and individuals which support the rights of employers and employees to decide the work and family benefits which are best suited to their individuals and mutual needs. Small businesses strongly oppose mandated benefits. The recommendation to reject any type of mandated benefits was ranked second by delegates to the 1986 White House Conference on Small Business. Health insurance was specifically mentioned as a benefit that small employers want to maintain as voluntary. ISSA recognizes the importance of providing adequate health care benefits and encourages its members to offer such benefits voluntarily. However, we oppose an across-the-board mandate which would require all employers to provide a fixed package of benefits regardless of the needs of the workers or the economic status of the employer.

ISSA members are strongly opposed to legislation which would require employers to provide health insurance for all full and part time employees (working more than 17.5 hours per week) and their dependents. We believe that most employers offer the best possible health insurance package to their employees. In some cases, companies are able to provide free coverage, depending on a number of factors. In other cases, the employee must bear the cost. In any case, the answer is not to impose mandatory requirements on every employer. We ask this Committee to consider the following facts:

1. Private Sector is Best Equipped: In an ever changing, fast paced, complex marketplace, the private sector is best equipped to provide a flexible and efficient response to a changing workplace environment. Employers are offering new customized benefit

packages to their employees in even greater numbers to meet the needs of their employees. Cafeteria style plans, which allow employees to select specific benefits from a "menu" of choices, are an example of how the private sector has developed innovative approaches to provide benefit programs to meet the specific needs of its employee population.

Because it is necessary to keep highly qualified individuals in this business, companies are striving to provide an attractive benefits package. This trend is likely to continue. The low birthrate of the 1970's has resulted in a shrinking labor pool. Employers, therefore, face intense competition to recruit and retain workers. Simple principles of supply and demand without government intervention requires employers to develop benefit packages customized to the needs of workers.

Competition requires employers to tailor their benefit programs to fit the particular needs of their employees. Consequently, benefits differ from company to company reflecting the different needs of workers. Indeed, the job marketplace itself dictates the type of benefits a company must offer in order to attract the best employees. It is not necessary for the Government to intervene and mandate a new series of costly benefits.

2. Federal Mandated Benefit Legislation is Not Necessary: Virtually all ISSA members offer hospitalization and major medical insurance as a fringe benefit to their employees without government intervention. These benefit packages are specifically tailored to the workers' needs and the companies economic capabilities. Some companies do not offer health benefits because of economic considerations. In addressing the need for health care, the government must take this factor into consideration. The government's first option, therefore, should be to provide economic incentives to employers to provide such benefits. This option would allow employers the flexibility necessary to meet the specific needs of their employees. Such a course of action is preferable to the imposition of a mandate which ignores the economic capability of employers and the specific needs of employees.

3. Federally Mandating Benefits is Dangerous Public Policy: It is dangerous public policy to require the private sector to provide a specific employee benefit as a cost of doing business. We respectfully submit that Congress is not in a position to weigh the benefits and burdens and to respond on an evolving basis regarding every problem involving health insurance. Businesses are far more capable than the government of weighing the advantages and disadvantages of various employee benefits and of responding in a timely manner to the changes in needs and circumstances.

4. Mandated Health Insurance Will Adversely Affect Existing Benefits: It is also inevitable that mandated health insurance would have an adverse effect on other benefits offered by small business. Many employers offer dental insurance, disability payments, sick leave, paid vacations, profit sharing and retirement plans. These benefits cost a company up to 37 percent of wages, for each employee, but they have been voluntarily provided without mandate from the government.

If mandated health benefits are enacted, many employers would have to reduce or end some of these other benefits that in fact employees may prefer. Because coverage for private physicians and hospitals are higher, employers would probably adopt lower cost health maintenance organization plans (HMO's), which most employees do not prefer. In addition, a mandated approach would also seriously disrupt current health benefit plans which have developed through careful negotiation. Under these circumstances, mandated health insurance would be detrimental to employee benefit programs.

5. Mandated Benefits Will Curtail Employment Opportunities: With the passage of this type of legislation, our companies could not afford to offer the same type of employment opportunities to large segments of the population which are dependent on this source of income. We believe that employers would have to reassess the type of person it needs for producing or formulating sanitary products. The number of opportunities would necessarily

decrease as employers would attempt to curtail anticipated expenses for certain types of workers, particularly part time and temporary workers. Business would have no incentive to expand and create new jobs. Overall, the U.S. economy would suffer because the vast number of jobs provided by small business in this country would be diminished.

6. Mandated Benefits Primarily Affects Small Business: The cost of providing a minimum health benefits package to all full and part time employees and their dependents is especially damaging to a small business.– Small companies pay a higher premium than larger companies because there are fewer members in the group. These costs would disproportionately affect small employers who typically operate on a low-profit margin. Thus, any mandate that increases payroll costs will inhibit a small business' ability to survive attempts to address this situation by creating a business subsidy. However, this provision only provides for reimbursement based on gross revenue as opposed to income. This type of scheme would certainly not adequately reimburse small businesses. In addition, the subsidy itself must come from tax dollars which will inevitably be increased to provide for such a subsidy.

7. Low Income Workers Would Not Be Benefited: Employment opportunities for lower paid workers could be altogether eliminated by the higher cost of providing for those workers. Part-time employees working more than 17 1/2 hours per week will undoubtedly see a reduction in their work hours. The added cost of health insurance will depress wage rates and keep those artificially low. Additionally, forcing low-income workers to pay 20 percent of a health insurance premium is a far greater burden than for those at the higher income scale. Therefore, mandatory health programs clearly represents a regressive payroll tax, hurting again, those it most seeks to help.

8. Mandated Policies Makes Us Less Competitive: If health insurance is mandated, our segment of the American economy could no longer be competitive. If we were unable to absorb or pass on the additional cost, then it would be inevitable that many companies would

either curtail or cease their operations. The European economy is an example of such an economic malaise. Burdened by mandated benefits, European businesses have lagged far behind the U.S. in terms of job growth and general economic health.

9. Mandated Benefits Increase Medical Care Costs: The rising costs of American health care has become a national problem. While the inflation rate for goods and services has increased 110.6 percent since 1960, the inflation rate for medical care has increased 800 percent during the same time period. A mandated health insurance program would increase the cost of medical insurance for employer and employee alike, and would do nothing to address the escalating costs of medical care. In fact, the legislation would exacerbate the problem by creating a higher demand for medical care which would cause a subsequent rise in prices. The higher cost of medical care will obviously translate into a higher premium cost for medical insurance, thus adding further to the burden of the private sector employer and employee.

CONCLUSION

In conclusion, we at ISSA do not oppose providing benefits to our employees, but we do strongly reject the notion that the Federal government should intervene into the marketplace to specifically require a mandated benefits program.

Small business, which is the greatest generator of new jobs and opportunities, needs the flexibility to offer a series of employee benefits, not a series of mandated responsibilities. If we as a society want to encourage job creation, increase competition, and stimulate productivity, we need to allow companies to provide the needed benefits to take care of their employees without adversely impairing the small business sector.

On behalf of ISSA and its members, I thank you for considering our position on this issue, and for appreciating that small business needs encouragement, not mandates, for taking care of its workers.

NORTH SLOPE BOROUGH
OFFICE OF THE MAYOR
P.O. Box 69
Barrow, Alaska 99723

Phone: 907-852-2611

George N. Ahmaogak, Sr., Mayor

Incorporated July 2, 1972

May 1, 1989

Honorable Edward Kennedy
Chairman, Committee on Labor and
Human Resources
United States Senate
428 Dirksen Senate Office Building
Washington, D.C. 20510

RE: BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT

Dear Senator Kennedy:

On behalf of my constituents, I enclose testimony voicing the North Slope Borough, Alaska's opposition to S.768, the Basic Health Benefits For All Americans Act as it pertains to mandatory health insurance coverage for municipal workers. As it is currently drafted, the bill would cost the Borough an additional $1.6 million from a decrease in job opportunities caused by these increased costs.

The Borough would like to work with your Committee to resolve this problem. Our comments include an amendment which we believe solves the problem without jeopardizing the purpose of the legislation.

Thank you very much for permitting me the opportunity to comment on this important piece of legislation.

Sincerely,

George N. Ahmaogak, Sr.
Mayor

Enclosure

STATEMENT OF GEORGE N. AHMAOGAK, SR.
MAYOR, NORTH SLOPE BOROUGH, ALASKA

HEARING ON S. 768, THE BASIC HEALTH
BENEFITS FOR ALL AMERICANS ACT
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
MAY 1, 1989

DEAR MR. CHAIRMAN. MY NAME IS GEORGE AHMAOGAK AND I AM THE ELECTED MAYOR OF THE NORTH SLOPE BOROUGH. THE BOROUGH IS THE MUNICIPAL GOVERNMENT FOR THE NORTH SLOPE OF ALASKA AND HAS APPROXIMATELY 8,000 RESIDENTS, OVER HALF OF WHOM ARE NATIVE INUPIAT ESKIMOS. THE BOROUGH ENCOMPASSES EIGHT VILLAGES COVERING AN AREA THE SIZE OF MINNESOTA AND RHODE ISLAND COMBINED.

TODAY I AM SUBMITTING COMMENTS ON A MAJOR PIECE OF LEGISLATION THAT YOUR COMMITTEE IS CONSIDERING THIS CONGRESS: S. 768, THE BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT.

THE NORTH SLOPE BOROUGH IS STRONGLY OPPOSED TO PASSAGE OF S. 768, THE BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT AS IT IS NOW DRAFTED. ALTHOUGH THE BOROUGH APPLAUDS YOUR EFFORTS TO ENSURE THAT ALL AMERICANS HAVE ACCESS TO HEALTH CARE, I FEEL THAT THE BILL CONTAINS A FEW PROVISIONS THAT WILL HAVE A NET EFFECT OF INCREASING COSTS FOR LOCAL GOVERNMENTS. THIS BILL CURRENTLY WOULD MANDATE, IN PERTINENT PART, THAT STATES AND THEIR POLITICAL SUBDIVISIONS AND AGENCIES PROVIDE MINIMUM HEALTH INSURANCE BENEFITS FOR ALL WORKERS WHO PERFORM SERVICES FOR AT LEAST 17.5 HOURS PER WEEK. THE BILL DOES NOT EXCEPT FROM COVERAGE MUNICIPAL PROGRAMS TO TRAIN AND EMPLOY WORKERS WHO WOULD OTHERWISE NOT BE EMPLOYED OR WORKERS TEMPORARILY EMPLOYED AT HIGH WAGES FOR SPECIFIC PROJECTS.

PASSAGE OF THIS BILL WOULD AFFECT TWO BOROUGH JOBS PROGRAMS. THE MAYOR'S JOBS PROGRAM SPENDS $2-$4 MILLION A

YEAR IN WAGES TO PROVIDE JOBS TO THE UNEMPLOYED IN AN EFFORT TO STIMULATE A STAGNANT LOCAL ECONOMY. THESE PEOPLE WORK FULL-TIME, BUT FOR SHORT PERIODS. TO REQUIRE THE BOROUGH TO PROVIDE THESE WORKERS HEALTH INSURANCE BENEFITS WOULD SERIOUSLY JEOPARDIZE THE CONTINUATION OF THE PROGRAM. THE BOROUGH WOULD NEED TO SPEND $800,000 A YEAR ON HEALTH INSURANCE PREMIUMS TO COVER THESE WORKERS. THUS, FEWER JOBS WOULD BE AVAILABLE TO PROVIDE TRAINING TO THE UNEMPLOYED WHO, IN TURN, COULD USE THE SKILLS LEARNED TO SECURE PERMANENT MUNICIPAL OR PRIVATE SECTOR POSITIONS.

S. 768 WOULD ALSO AFFECT ADVERSELY THE BOROUGH'S CAPITAL PROJECTS PROGRAM. LABORERS PROVIDE MOST OF THE WORK AND THESE WORKERS ARE COVERED BY EITHER OR BOTH THE FEDERAL DAVIS-BACON ACT OR THE ALASKA DAVIS-BACON ACT, TITLE 36 OF ALASKA REVISED STATUES. THESE STATUTES CONFER HIGH WAGES AND A MULTITUDE OF BENEFITS ON THESE WORKERS. THE RESULTING

WAGES ARE $27-$30 AN HOUR. TO IMPOSE AN ADDITIONAL BENEFIT OF HEALTH INSURANCE WOULD INCREASE THE COST OF THIS PROGRAM BY $800,000, DECREASE THE AMOUNT OF WAGES, AND MAKE SUCH JOBS LESS ATTRACTIVE TO THESE WORKERS. MOREOVER, AT THESE HIGH WAGES, THE AFFECTED WORKERS ARE PERFECTLY ABLE TO PROVIDE FOR THEIR OWN HEALTH INSURANCE IF THAT'S THE WAY THEY WANT TO SPEND THEIR MONEY. THESE WORKERS ARE UNINTERESTED IN TRADITIONAL "FRINGE BENEFITS," INCLUDING HEALTH INSURANCE, AND PREFER TO SELECT WHATEVER BENEFITS THEY WANT IN THE OPEN MARKET.

IN ADDITION, A MAJORITY OF WORKERS IN BOTH THE MAYOR'S JOBS PROGRAM AND THE TEMPORARY PROJECTS PROGRAM IS ALASKA NATIVE AMERICANS. THESE NATIVES RECEIVE FEDERAL MEDICAL CARE PURSUANT TO THE TRUST DOCTRINE, THE SNYDER ACT, 25 U.S.C. § 13 ET SEQ., AND THE INDIAN HEALTH CARE IMPROVEMENT ACT AND ITS AMENDMENTS. TO REQUIRE PROVIDING MANDATORY HEALTH

INSURANCE COVERAGE FOR THESE NATIVES WOULD DUPLICATE EXISTING COVERAGE AT NEEDLESS COST.

THE BOROUGH TAKES PRIDE IN ITS HUMANISTIC VIEW OF ITS RESPONSIBILITY AS A GOVERNMENT EMPLOYER. IT CURRENTLY PROVIDES HEALTH INSURANCE FOR ITS PERMANENT, FULL-TIME WORKERS. THE BOROUGH DOES NOT PROVIDE HEALTH INSURANCE TO JOBS PROGRAM OR CAPITAL PROJECT WORKERS FOR THE REASONS I HAVE SET OUT ABOVE. IF THE BOROUGH DOES NOT COMPLY WITH THE REQUIREMENTS OF S. 768 FOR THESE TEMPORARY FULL-TIME WORKERS IT WOULD BE METED OUT A HARSH PUNISHMENT: THE WITHHOLDING OF FEDERAL GRANTS, LOANS OR OTHER FINANCIAL ASSISTANCE FROM PROGRAMS AUTHORIZED BY THE PUBLIC HEALTH SERVICE ACT. THE PUNISHMENT IS ALL THE HARSHER BECAUSE SUCH A MANDATE WILL FORCE THE BOROUGH TO CHOOSE BETWEEN HAVING A JOBS PROGRAM AND PROVIDING HEALTH INSURANCE.

TO PREVENT THE LOSS OF THESE VALUABLE MUNICIPAL PROGRAMS, I OFFER AN AMENDMENT TO CORRECT THE SITUATION. THE AMENDMENT SEEKS ONLY TO CLARIFY THE EMPLOYMENT COVERAGE INTENDED TO BE PROVIDED BY S. 768. UNDER THE AMENDMENT, STATE OR MUNICIPAL WORKERS WHO PERFORM SERVICES ON TEMPORARY, SHORT-TERM PROJECTS OR WHO WORK FULL-TIME FOR LESS THAN 180 DAYS WOULD NOT BE CONSIDERED "EMPLOYEES" UNDER THE BILL. STATE AND MUNICIPAL GOVERNMENT EMPLOYERS OF THESE TEMPORARY WORKERS WOULD NOT BE REQUIRED TO PROVIDE HEALTH INSURANCE FOR THESE WORKERS. ALL OTHER STATE AND MUNICIPAL EMPLOYEES WOULD REMAIN COVERED BY THE LEGISLATION.

THE BENEFITS OF PROVIDING JOBS TO THESE WORKERS FAR OUTWEIGHS THE ABSENCE OF HEALTH INSURANCE BENEFITS. UNDER THE PROPOSED AMENDMENT, THOSE WHO ARE JOB TRAINEES WILL BE ELIGIBLE FOR MEDICAL INSURANCE BENEFITS AFTER THEY WORK 180 DAYS FOR A GOVERNMENT OR IMMEDIATELY UPON FINDING A

POSITION WITH A PRIVATE EMPLOYER. MOREOVER, TEMPORARY LABORERS ACCUSTOMED TO EARNING A HIGH SALARY LEVEL WILL NOT LOSE THE FREEDOM TO CHOOSE WHAT TYPE AND HOW MUCH HEALTH INSURANCE COVERAGE THEY WANT.

SECTION 303(3) OF TITLE III, SUBTITLE A OF S. 768 IS AMENDED BY ADDING AFTER (D), THE FOLLOWING SUBPARAGRAPH:

(E) TEMPORARY MUNICIPAL EMPLOYEES

(i) THE TERM "EMPLOYEE" DOES NOT INCLUDE A TEMPORARY MUNICIPAL EMPLOYEE.

(ii) THE TERM "TEMPORARY MUNICIPAL EMPLOYEE" MEANS AN INDIVIDUAL EMPLOYED BY A STATE, POLITICAL SUBDIVISION OR AGENCY THEREOF, OR MUNICIPALITY TO PERFORM SERVICES FOR A

MUNICIPAL PURPOSE FOR A SPECIFIC SHORT-TERM PROJECT WHERE WAGE LEVELS ARE SUBJECT TO 40 U.S.C. § 276A, THE DAVIS-BACON ACT, OR ITS STATE STATUTORY EQUIVALENT, OR FOR LESS THAN 180 DAYS.

(iii) THE TERM "MUNICIPALITY" MEANS STATE OR LOCAL GOVERNMENTAL ENTITY OR AGENCY HAVING GENERAL PURPOSE GOVERNING POWERS.

THE NORTH SLOPE BOROUGH'S PROBLEMS CONCERNING THIS LEGISLATION ARE ONLY ILLUSTRATIVE OF THE MANY BURDENS THAT WILL FALL ON NOT ONLY GOVERNMENTS BUT ALSO SMALL BUSINESSES IF THIS LEGISLATION IS ENACTED. THOUGH ITS GOALS ARE BENEFICENT, THE BILL'S IMPLEMENTATION NEEDS TO BE FINE-TUNED SO THAT OTHER VALUABLE AND USEFUL METHODS OF PROVIDING FOR AMERICANS ON A LONG-TERM BASIS ARE NOT OVERLOOKED.

WE BELIEVE IN GOOD GOVERNMENT AND GOOD BENEFITS FOR GOVERNMENT WORKERS, BUT CAUTION THAT JOBS SHOULD NOT BE FORSAKEN DUE TO COSTS INCURRED TO PROVIDE INSURANCE.

I THANK THE CHAIRMAN FOR THIS OPPORTUNITY TO COMMENT ON THIS LEGISLATION AND HOPE THAT THE EQUITABLE SOLUTION I PROPOSE WILL BE ACCEPTED BY THE COMMITTEE.

Senator Durenberger. Well, perhaps you can amplify on today's statement for the benefit of this record with some of those suggestions.

Does anybody have any other comments?

[No response.]

Senator Durenberger. Thank you all very much for your testimony.

The hearing is concluded.

[Whereupon, at 1:21 p.m., the Committee adjourned.]

BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT

FRIDAY, JUNE 23, 1989

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:06 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Matsunaga, Simon, Hatch, and Durenberger.

The CHAIRMAN. The committee will come to order.

I had the opportunity to meet Mr. Buckland, who will be joining us in a minute or two, so we might get started with our hearing. We have some very important witnesses today, and I am reluctant to enforce the five-minute rule for them. We are faced with a conflict where the ABC bill, which is a bill out of this committee, is moving through and is in, hopefully, its final hours on the Floor of the Senate, plus a memorial service for Goodman, Chaney and Schwerner, who were the three young civil rights workers who were brutally murdered in Mississippi during the civil rights movement. I will be attending that memorial service. So I appreciate the understanding of the witnesses, many of whom have come long distances, and we will include all of their full statements in the record and follow the five-minute rule. If we are not inundated with colleagues and other members, we will have a little longer period of time if we don't have extensive questioning. So that is the way that we will proceed today.

As the Basic Health Benefits for All Americans bill has advanced through the legislative process, a number of concerns have been raised about its impact on small business. Our hearing will examine the conditions small business owners face when they attempt to buy the health insurance coverage for their employees as well as for themselves.

I believe that basic health benefits legislation is as essential for small business owners throughout America as it is for any other citizen who needs the access to essential health care and the freedom from fear of financial ruin that only health insurance coverage can bring.

The current insurance market for small businesses is a disaster area. They must pay an average 20 percent markup compared to the cost to large firms for identical coverage. Very small businesses—those with ten employees or less—pay a markup of as much as 35 percent, or even more.

But high costs are only the beginning of the problems that small businesses face. No firm can count on access to health insurance even if it is willing to pay an exorbitant price for coverage. In today's highly competitive and increasingly segmented market, whole categories of small business are simply redefined out of access to coverage.

Even those enterprises not automatically excluded face severe restrictions when they apply for coverage. If any employee of the group has an illness that the insurer thinks might prove costly, the whole group is likely to be excluded from coverage. Even if coverage is granted, it will be fenced off with so-called exclusions of pre-existing conditions, so that the employees will not be covered for the very illnesses likely to result in costly medical care.

Even small businesses that find coverage without such exclusions are still not home-free. Groups that are healthy when coverage begins often develop some serious illnesses among the employees or the owners. All too often when that happens, the affordable coverage originally purchased evaporates.

Insurance companies often respond to new losses on such groups not by looking back to all the years in which premiums exceeded the costs, but by deciding not to sustain further losses.

Typically, the small business that has suddenly been transformed from a good risk to a bad risk finds that its coverage is cancelled, or that the premiums rise to levels the business can no longer afford to pay.

Because of these concerns, a shake-out is taking place in the small business today. A number of insurance companies are dropping all of their existing small business coverage. In recent months, my office has received numerous desperate calls from small business owners who have found their coverage cancelled and who know they have health problems that will preclude them from finding coverage elsewhere.

This constant turmoil and instability in the marketplace generates excessive costs for small business. It is reasonable to expect that the unit costs of serving small business will be higher than the cost of serving larger firms. But the extreme discrepancy in cost is a direct result of the current market failure. Small businesses are being gouged because the cost of constant enrollment and disenrollment, selling and reselling, drives up the cost of coverage.

As a result of these conditions, many small businesses do not provide coverage for their employees. What is remarkable is that the majority of small business employees in the country still have coverage.

It is time to give all small businesses a better deal. The basic health benefits bill provides the kind of relief they need. The bill establishes a system of private, regional insurers. Any insurance company can participate, but only if it is willing to play by a set of rules that will be fair to the small businessman and the regional insurer alike.

Under these rules, coverage is guaranteed—a regional insurer must accept any small business that applies. Pre-existing condition exclusions are prohibited, so that no worker or his family will go unprotected because they have the misfortune to be ill.

Coverage is community rated, so that every business is charged a fair, stable, average rate; no business pays a premium because someone in the firm gets sick.

Coverage will be standardized for plans so that businesses can make an informed choice between companies. Insurers will compete on the basis of the efficiency with which they can arrange to deliver care and process bills, not on the cleverness with which they can design plans to attract the fewest risks.

The regional insurer structure will also assure the availability of cost-effective managed care, such as HMOs, to any small business that wants it.

Finally, the legislation preempts State-mandated benefit laws, which often require coverage of nonessential services and unnecessarily raise the costs of health insurance to small business. Large firms can self-insure and exempt themselves from these requirements. The basic health benefits bill levels the playing field by requiring large and small businesses to meet only the same fair minimum requirements.

The respected Actuarial Research Corporation estimates that the administrative savings as a result of this structure will average 10 percent. Savings to small businesses who buy coverage from the managed care providers can save an additional 15 percent. The result is a net savings of up to 25 percent for small businesses. But even more important than these savings is the right of all small businesses to a fair, stable community rate.

By itself, the regional insurer structure makes this legislation attractive to small business. In addition, the legislation builds an important further protection: It provides that if the cost of compliance exceeds 5 percent of a firm's gross revenues, the Federal Government will subsidize the coverage.

For industry groups for which the 5 percent standard is not appropriate, the Secretary of HHS is directed to establish an alternative equivalent standard. This protection is modelled after comparable protection in the mandated health benefit program in Hawaii, which has effectively served the people and the businesses of that State for more than a decade.

A number of alternatives to basic health benefits have been advanced as opponents of our legislation become increasingly aware of its potential. This alternatives include fairer tax treatment for small businesses, preemption for State-mandated benefit laws, encouragement of voluntary pooling arrangements like multiemployer trusts, and high-risk pools for uninsurable businesses and individuals.

Our legislation already incorporates fairer tax treatment and preemption. As the testimony today will show, voluntary pooling arrangements cannot solve the small employer problem. These arrangements, if established on a voluntary basis, are subject to the same competitive pressures undermining the current small business market. They cannot eliminate medical underwriting, pre-existing condition exclusions and excessive costs.

High-risk pools provide guaranteed coverage for small businesses that cannot purchase coverage today because of medical problems—but only at a large markup over the already inflated prices characteristic of the current market. Most small businesses cannot afford to participate. The availability of a high-risk pool does nothing to reduce the high costs faced by small businesses or to overcome the problem of pre-existing condition exclusions.

Most basic of all, these so-called "solutions" fail the ultimate test—they do not guarantee the fundamental human right to health care to all of our people.

Small businesses view Government requirements with justifiable suspicion. They do not employ high-priced lawyers or full-time benefits managers to help them wend their way through a maze of Federal regulations. But I believe any small business owner who carefully considers the benefits of the basic health benefits bill in comparison to the current system will demand prompt action. This legislation provides a remedy that small business can not only live with, it can prosper under.

The Senator from Utah.

Senator HATCH. Thank you, Mr. Chairman.

I want to say I appreciate you providing us the leadership in examining our health care system. Although we differ quite a bit on how we should solve these problems, I still think without your leadership these issues would not be issues that are being considered as seriously as they are today. Mr. Chairman, I have a great deal of respect for your leadership in the health care field, and I commend you.

There are two things I have learned about our current health care system. Number one, it is the best in the world, and number two, there are some people who are not covered by health insurance, and we have to do something about that.

If we want to continue to think of our health care system as the best in the world, we have to find a way to ensure that all of our citizens share in its quality.

According to the 1988 Census Bureau report, there are 205.7 million Americans who have health insurance coverage. However, according to Senator Kennedy and myself, there are 35 million Americans who lack health insurance. Many of these are workers and their dependents.

There are many reasons why these workers do not have coverage, and one primary reason, of course, is rising health care costs. In my opinion, every American should have access to health care, and we have to find solutions in order to reach that goal.

However, it is no secret that I strongly oppose Senator Kennedy's solution in S. 768. While our access to health care problem has multiple causes, Senator Kennedy's legislation, mandated health insurance, has placed the responsibility for solving it in one place—that is, on the backs of employer and employees at a cost of between $30 to $100 billion a year.

Today, I will be introducing legislation that is a complex solution which recognizes that we all have responsibilities in helping all Americans gain access to health care. Employers have responsibilities, employees have responsibilities, health care providers have responsibilities, and local State and Federal Governments have responsibilities.

Six months ago, I asked representatives from the business community, health insurers, health care providers and general health care experts to help me draft legislation to cure our health care malaise. The only restriction was that its cost must be closer to the $8 billion, the price of total uncompensated hospital care currently provided.

They helped in the formation of legislation that I will introduce. It is based on five principles. One, Medicaid should be returned to its original purpose, that is, to provide health care access to the economically disadvantaged. Two, Federal incentives which help make health insurance affordable should treat all Americans equally. Three, an ounce of prevention is worth billions—maybe even trillions—in cures. Four, defensive medicine is really costly medicine. And five, health care providers should not shoulder the costs of uncompensated care alone.

The fundamental key to these proposals is to make health care insurance more affordable. Affordable health care gives us greater access to health care.

One key issue to reduce costs that I would like to specifically address is medical liability reform.

Medical liability is adversely affecting our health care system in three ways. First, we are paying about $4 billion per year, or about 8 percent of our health care dollars for medical liability costs.

Second, according to Joseph Califano—certainly an acknowledged expert in this area—we are paying another $121 billion in 1987 dollars for defensive medicine. That means for every dollar we pay in medical liability costs, we are paying another $30 billion in defensive medicine costs.

The third adverse effect is the loss of access to health care. Because physicians are scared about medical liability, they are abandoning certain areas of their medical practice thereby reduce access to health care.

So we have the total pie, $500 billion in health care costs, with the $125 billion in defensive medicine. Most of this money should be saved by society rather than just shot down the drain because of the fear of doctors that they might be sued for medical malpractice.

I have several charts that I would like to go through. The first one represents what I have just mentioned, the cost of defensive medicine. The second chart shows some of the changes physicians say they are making in response to the liability crisis.

Seventy percent of physicians say they are getting more medical consultations. Sixty-six percent say they are ordering more diagnostic tests. And, 54 percent say they are scheduling more follow-up visits. In addition, 28 percent of physicians say they are performing more procedures themselves rather than delegating them to other, less costly health care professionals.

The next chart displays how many dollars physicians think they are spending on unnecessary defensive medicine each year. Seventy-nine percent of our physicians say that they order at least $10,000 of unnecessary medical each year—that is 79 percent of them. Twenty-six percent order $50,000 or more each year of unnecessary medical care. And, a shocking 14 percent of our physicians say that they order more than $100,000 worth of unnecessary health care for defensive medicine purposes each and every year.

Interestingly, only 4 percent of our physicians feel they order less than $1,000 of unnecessary tests per year.

Now, I don't think there can be any question in the minds of members of this committee that we are wasting tens of billions of dollars—actually, $125 billion, in a very real sense—on defensive medicine every year, and that the most important single step this committee could take to reduce health care costs while maintaining good quality is to do something about the liability crisis. Again, Senator Kennedy is showing great leadership in this area. He has indicated to me that he would like to look at medical liability reform and see what we can do to resolve these problems. I think this is a real incentive to us. It may be that we can find the dollars that we need for expanding access to health care in just getting a percentage of these unnecessary costs from the system, working for the system.

As I mentioned, defensive medicine is not only affecting health care costs, but it is also affecting availability. This next chart shows how many physicians have eliminated services. In a period from 1982 to 1988, 90 percent of the family physicians eliminated services, 71 percent of internists eliminated services, and 72 percent of our ob/gyns eliminated services primarily because of the high cost of liability insurance—a lot caused by the fear of being sued for medical malpractice—and unjustly sued at that. There is no question that I am a strong supporter of litigation to correct medical malpractice. It is an appropriate tool to be used by society, but not the way this is happening.

The next chart looks at one specific type of care, and that is obstetrical care. In that same period, 63 percent of all family physicians stopped providing obstetrical care, and 36 percent of our ob/gyns stopped providing obstetrical care.

I know that the members of this committee are concerned about infant mortality and the availability of prenatal care in this country. I think this chart points out why we don't have prenatal care available today. I daresay that even if the taxpayer of this country gave this committee a blank check to expand prenatal care, the problem will not be solved unless we also address this liability crisis.

Without providers, there is no prenatal care.

Today I will introduce legislation entitled, "The Comprehensive and Uniform Remedy for the Health Care System Act of 1989"—the acronym is "CURE". It is intended to change our health care system by improving the health of mothers and their babies, removing barriers to affordable health insurance, improving health care costs through prevention and public awareness programs, and improving the trauma care system.

Two other parts are being readied for introduction to address expanding Medicaid, equalizing tax credits, and reforming the medical liability system.

Together, these comprehensive reforms are designed to reduce health care costs, to share responsibility for providing access to health care, and to make it easier for businesses of all sizes to offer health care services and for providers to extend health care services.

I look forward to hearing the testimony of today's witnesses and working on new approaches to expand the availability of health care while reducing the costs.

Mr. Chairman, as you know, I am on the Floor in the child care battle, and I must go. But I notice that one of the witnesses, David A. Raine, is placed on Panel II, and if you would do this for me—I would like to hear all three of them, if I can, before I go—I think that would be appropriate, and I would at least like to try and stay for the first panel, if that would be possible.

The **Chairman**. Out of consideration to our Ranking Minority member, Mr. Raine can come up. I'd like to hear the first two witnesses first.

Senator **Hatch**. Sure. I appreciate it. Could Mr. Raine come up and be at the table?

The **Chairman**. Yes.

Senator **Hatch**. Thank you, Mr. Chairman.

The **Chairman**. Senator Simon.

Senator **Simon**. Thank you, Mr. Chairman.

First, I'd like to join in commending you for your leadership. I am pleased to be a cosponsor of this legislation.

I think my colleague from Utah is talking about a very serious problem—if I may have his attention—in this area of liability. But frankly, if we were to cure that tomorrow—and there is some evidence that medical liability insurance is going down now instead of going up——

Senator **Hatch**. Primarily because you have adopted reform. In Illinois, you have adopted reform, and we want to give your State credit for it.

Senator **Simon**. I think this is happening nationally——

Senator **Hatch**. Oh, I don't think so.

Senator **Simon** [continuing]. And it may be because of what States are doing.

But even if we were to solve that problem tomorrow, it does not solve the problem of people who have no health insurance. I think we have to face this problem. It is not a cure for all of our problems.

I think there is a general feeling that the health care delivery system is not what it should be in the United States today. The *Chicago Tribune* did a poll—I think it was Peter Hart poll—one in Canada and one in the United States. In the United States, 9 percent of the public is satisfied with its health delivery system; in Canada, 56 percent of the people are satisfied with the health delivery system.

I run into small business people who are concerned about what is happening. I think there is one provision in the bill that protects small businesses, and that is the 5 percent limitation. I also believe that we could work out something where, in each State—in Utah, in Massachusetts, in Illinois, and in Minnesota—you could have the insurance companies bid on what they could cover for 40 cents an hour for businesses that are not now covered. We could at least provide a minimal amount of coverage. Whatever insurance bid the highest in terms of coverage would get it for Minnesota or Illinois or whatever the State might be. That would limit the liability for that small business.

But right now, the costs to other businesses not now covered are very, very real. Businesses who cover their employees also have to pay through Medicaid and in other ways for businesses that provide no coverage. The costs to society obviously are very real. We run into them every day when we are out in our States. And the costs in other ways—to hospitals—32 hospitals in Illinois have closed in the last nine years; 81 hospitals in Texas have closed in the last nine years—almost all in poorer areas of those States. And a good chunk of that is because they serve these poorer people who have Medicaid coverage. The States vary appreciably on the kind of Medicaid coverage they provide, and they cannot provide full cost. If we had insurance coverage for these 37 million Americans, I think we would have a much, much better situation in our society.

So I am looking forward to hearing the witnesses, and I hope we can come up with something that really can protect our people more adequately.

I would add one other point, Mr. Chairman, and that is we are going to save Federal dollars if we do this because we will end up not paying so much in Medicaid. So it just seems to me it is clearly in the national interest that we move ahead.

Thank you.

The CHAIRMAN. Thank you very much.

Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you for the opportunity to discuss this incredibly important issue again. Let me say what I said in the Finance Committee when you appeared earlier this week. All of us know Ted Kennedy, and even those of us who did not know him personally before we came to the United States Senate have always associated him with a couple things. One is the quality of public service in this country; second is equal access to public service in this country.

It just so happens that in the early days, that was associated with health care. And here we are, it continues to be associated with health care now and a variety of other areas.

The Ranking Member of this committee also has both a national and an international reputation on his commitment to health care—and so does everybody else in this committee to some degree—but that is the reason that, when I was given the opportunity to add another committee this year, I came over to this committee. I find it a great opportunity, and certainly it is an opportunity I intend to take advantage of.

But there is one other committee and commission operating in this country today that nobody knows much about, now called the Pepper Commission, out of respect for the person who in effect caused it to be created. And as things would have it, we didn't have much to do with that over on this side of the Capitol. It was created because the House of Representatives last year defeated a long-term care bill that was sponsored by Claude Pepper. And in exchange, in effect, for taking the temporary defeat of long-term care legislation which Claude Pepper wanted, the House was wise enough to create the United States Bipartisan Commission on Comprehensive Health care, because the members of the House and the members of the Senate, I think, understand that you can't do long-term care for chronically ill Americans unless you also address the issue that these two gentlemen—all four of us, I guess—intend to address here, and that is comprehensive health care.

Can the United States ever get to the point where it can guarantee each of its citizens financial access to high-quality health care?

As we go about the job of closing the gap in this system, it is well to point out what is wrong with the system. It is well to point out, as Senator Hatch did, that there are too many incentives in the system today to spend unwisely. It is well to point out the fact that there is too much defensive medicine.

But the point that I think most Americans miss—and I think this is reflected in the polls that Senator Simon pointed out to us—and I hate to make this comparison—but buying health care in this country today is a lot like having your car fixed. You know the bill is much larger than you think it ought to be, and you really don't know whether they found out what was really wrong with you or whether it got taken care of.

I'll never forget the Democratic majority leader of the State Senate in Minnesota died of leukemia, but his life was prolonged because he knew Walter Mondale, and he was able, when he had a hint, when they finally diagnosed after several months back and forth, what was wrong with him—and he told me this when I saw him before he died—he said, "I just thank God that I knew the Vice President of the United States, and I could call up and I could get access" to what we think—we assume—is the best at NIH.

In Minnesota, we have the Mayo Clinic, and there is an assumption when you take your body to be fixed at the Mayo Clinic that they have probably done the best job. But do you really know? Does anybody really know?

At the heart of a lot of the problems that we all face in this country is that issue of quality of care. It also includes the redefinition of health. And everybody on this committee is committed to wellness and prevention and so forth, and yet we don't practice it in this country and we don't practice it in our reimbursement systems.

But the people who suffer the most are the little people. And whether it is in the cab driver in Chicago last year—I asked him about his health care coverage, and his wife had just had a C-section. He didn't buy health insurance because they paid him $75 a day in cash. He assumed the health insurance was too expensive, so he didn't buy insurance. So now they are hounding him for a $7,500 bill—and he isn't going to pay it. "I am not going to pay it." So that money is going to be added to somebody else's bill. And when it gets added to Chrysler's bill, nobody cares, because Chrysler is already up $600 a month and $700 a car, and there are tens of thousands of employees, and they don't care. But when it gets added to the bill of my friend, Pat Pappenfus back here, who is a small business person in Winona, Minnesota, it makes a whale of a difference. She cannot carry that cabbie much longer, and 37 million people like that in the rest of this country, because she doesn't have the big tax subsidy that Chrysler has. She doesn't have—you know, the more you pay out in health insurance, the more you get from the Government; the bigger you are, the more you get. She is just a small business person, like some of the folks we are going to hear from here today.

It is that growing inequity in who carries the burden for $550 billion a year in this country that all of us in one way or another are dedicated to resolving. It isn't fair that the big folks get more at lesser cost and a greater Government subsidy. We all ought to have equal access to equal care in this country, but figuring out how to get from here to there is a challenge of the folks at the head of this table who have been the national leaders in this issue for a long time, and it is particularly I think the challenge of those of you who come today to offer your suggestions.

Mr. Chairman, thank you very much for this opportunity.

The **Chairman**. Thank you, Senator Durenberger.

I think all of us appreciate your presence on this committee. You are unique in the Senate, serving on the committee here which is concerned about aspects of health care, and on the Finance Committee, which has responsibilities for health care, and also on the Bipartisan Commission. So there is no one in the Senate who comes to the health care issue with the vantage point that you do, and we are very glad to have both your presence and input. I believe we really have a unique opportunity, working in the Finance Committee and this Committee, to really try and address this issue in an important way.

Senator **Durenberger**. Thank you, Mr. Chairman.

The **Chairman**. We will move to our witness, Mr. Kelly Buckland. Kelly is director of an organization called Living Independence Network Corporation. He comes to us from Boise, ID.

We look forward to your testimony.

STATEMENT OF KELLY BUCKLAND, EXECUTIVE DIRECTOR, LIVING INDEPENDENCE NETWORK CORPORATION, BOISE, ID

Mr. **Buckland**. Thank you, Mr. Chairman and honorable members of the committee.

It is my pleasure to be here and talk to you this morning about such an important issue.

I am Kelly Buckland, and I am Executive Director of Living Independence Network Corporation, or LINC for short. I am also a member of the Idaho Citizens' Network.

LINC is an organization which works with people with disabilities to assist them in living more independently in their own communities. We provide advocacy, transportation, personal care services, independent living skills evaluation and training, and peer counseling. LINC is six months old and employs a staff of six. We are funded through a grant from the Rehabilitation Services Administration.

LINC has a budget which would allow us to give our employees health insurance coverage, but to date we have been unable to purchase an insurance package which would cover all of our employees. We are an organization whose hiring preference is to employ people with disabilities. We do not have enough employees to quality under Blue Cross/Blue Shield to take advantage of their open enrollment policy. The rest of the insurance industry has systematically excluded our employees with disabilities. This includes myself, the director of the organization.

It seems as though you can purchase insurance if you demonstrate no need to use it. However, if you have an ongoing health need, you are denied coverage.

Since our employees with disabilities have been denied health care coverage, we cannot extend health care coverage to any employee in the organization and stay in compliance with Section 89.

The result of this "Catch-22" is that no employee is getting health care insurance coverage from LINC, despite our ability to pay. Section 89 is penalizing our employees and our corporation for the unfair policies of the insurance industry. Meanwhile, LINC and all of its employees are being asked by Section 89 to bear the burden. This hardly seems fair. LINC did not choose to deny coverage to our employees; insurance companies did. Let's put the responsibility where it belongs.

I am currently exercising my option under COBRA legislation and have continued my coverage from my last employer, the State of Idaho. I have one year left before that coverage runs out, and I will be faced with a difficult decision. I cannot go without health insurance. If LINC is not large enough to qualify for open enrollment under the guidelines of Blue Cross/Blue Shield, I will need to seek employment with a larger organization of the State. I do not want to make that decision.

I am no stranger to insurance discrimination based on my disability. I could not get health insurance until I went to work for the State of Idaho in 1979. I was consistently viewed as a risk. Now, after ten years of progressive, professional experience, I am back in the same place.

With auto insurance, I have routinely paid $200 more per year strictly based on my disability. Eighteen years ago, the only company which would cover me was Dairy Land, a company dealing with high-risk insurance.

The life insurance industry is much the same story. Fifteen year ago, I purchased the only policy available to me in Idaho. It used a phased-in approach to demonstrate, I guess, that I was worth the risk if I lived for a period of five years.

In summary, Living Independence Network Corporation is a viable organization, playing an important role in several Idaho communities. We have funding, staff and a program. We are being unnecessarily penalized in the area of health care coverage for our employees by both the insurance industry and Federal policy through the Section 89 requirements.

The effects are harmful, harsh and unfair for both the corporation and its employees. As a small nonprofit business in the first year of operation, we certainly do not need to deal with this situation. We need to be building staff morale, not placing our people in very difficult circumstances. I must view LINC's situation as created by systematic discrimination and unfair policy.

The problem of insurance companies denying coverage is a problem not only for persons with disabilities; it is a problem for all person with any pre-existing condition. Our Nation must address the fact that health insurance companies have the ability to deny health care coverage to people, and neither we nor our employees have recourse.

This insurance industry privilege to determine who they will and will not accept must be examined. Mr. Chairman; the basic health benefits bill you are proposing would help assure that health care coverage for all Americans, regardless of their health status.

Thank you very much.

The CHAIRMAN. Thank you very much. We will hear from each of the panelists.

I am very familiar with that situation since I have a son who had cancer at the age of 12 and lost a leg to cancer. He is completely unable to get health insurance as an individual. So I am very familiar with the points that you make.

We will hear from our second witness, Lisa Carroll. Lisa is Director of Health Services at the Small Business Service Bureau, located in Worcester, Massachusetts.

Ms. Carroll, we will be glad to hear from you.

STATEMENT OF LISA CARROLL, DIRECTOR OF HEALTH SERVICES, SMALL BUSINESS BUREAU, WORCESTER, MA

Ms. CARROLL. Good morning, Mr. Chairman, and members of the Senate Committee on Labor and Human Resources. I thank you for the opportunity to address you today on the subject of affordability and availability of health insurance coverage for small businesses.

My name is Lisa Carroll, and I spent several years as a registered nurse in clinical practice For the past few years since I completed my Master's Degrees in both public health and in nursing, I have been serving as the Director of Health Services for the Small Business Service Bureau, Inc., a national membership organization for small businesses, which provides group benefits and services to many small companies.

One of the most vital services SBSB offers to small businesses is group health insurance through Blue Cross and Blue Shield carriers and health maintenance organizations.

We make available over 100 Blue Cross/Blue Shield and HMO plans nationally. We service many thousands of small business people who need health insurance every year.

Over the course of the past few years, I have seen the health insurance industry become more concerned with their bottom line than with providing health services to the people who need it most.

I am here to attest to the need for health legislation like that proposed by Senator Kennedy. His is a laudable effort to resolve a problem that is growing worse every year. It is a problem that can only be addressed on the national level.

Small business people traditionally have opposed mandating employee benefits. However, in annual SBSB member surveys, our small business members overwhelmingly favor Government regulation to control the cost of health care and health insurance premiums. In 1988, 78 percent of our small business members favored this type of Government regulation.

Small business, particularly those employing 50 or fewer people, need your help. Federal intervention is the only way they will gain access to affordable health insurance.

The rating practices in the small group market are becoming more and more restrictive, regardless of whether the coverage is traditional indemnity insurance, like Blue Cross/Blue Shield, insurance offered by commercial carriers, or insurance through health maintenance organizations.

Rates for indemnity coverage are now based on: experience of the group, age and sex of the subscriber, the territory or area in a State in which the particular business is located, contract type, and deductible. This can result in a matrix of over 500 rates for one product, making it very difficult for a small business person to buy health insurance.

If you are older, as many entrepreneurs are, you could pay as much as $10,000 or more a year for health insurance for yourself and your family.

Some carriers are also rating based on the experience of a small business. I know of a physician right here in Washington, DC who is paying over $17,000 a year. He was a physician in private practice. He had cancer, and he had a son with Down's Syndrome. His insurance was costing him over $17,000. He knew he had nowhere else to go for coverage, and he stayed with the plan he had, even though the rates were a considerable hardship for him.

HMOs were once an affordable alternative for small businesses. However, recent changes in the HMO Act permit HMOs to move away from their original directive to community rate toward more experience-based rating practices. This clearly benefits big businesses at the expense of small businesses. Now, even HMOs are becoming too expensive. Many HMOs have moved away from their original mission as affordable alternatives to traditional insurance, and are now running on a profit motive instead of on principles of quality service at affordable cost to those who need it.

HMO rates increased by approximately 30 percent this past year. In Massachusetts in particular, small businesses are paying almost $500 a month for family coverage.

There are some HMOs that are the exception. I find the Fallon Community Health Plan in Massachusetts has been offering affordable, accessible health care to the small business population successfully, and they have not restricted or discriminated against this. They are a model, I think, for the managed care industry.

Underwriting practices such as pre-existing condition exclusions, partial exclusions on certain medical conditions, waiting periods of up to 11 months before total coverage begins—and all this time in that 11-month period, you are paying full insurance rates—and total denials for coverage are common insurance industry practices which affect the access to health insurance for small companies.

Rather than describe these practices, let me give you examples of small business owners, their children and their employees who are the victims of such practices.

Mr. A, who owns a small business which buys and sells rare coins, lost his new employee to a large business because the employee could not pass medical underwriting for the health insurance coverage he offered as an employee benefit. The employee had a minor cardiac condition and was able to get health insurance through the big company he went to work for. Clearly, big business does not receive the same discrimination from carriers that small employers have to suffer.

Mrs. B had applied for indemnity insurance and was accepted, except that any treatment for nervous and mental disorders was excluded and would not be covered. She was receiving counseling at the time. About a year after her coverage began, she was diagnosed as having an inoperable brain tumor. Her physician recommended counseling for death and dying to help her cope with her terminal condition. The carrier would not pay, however, because of the prior exclusion. She continued to see a counselor as long as she herself could afford to pay—that is very difficult when you are self-employed and dying.

Small business owners who have pregnant wives are often denied coverage if the carrier is medically screening. If it is a guaranteed issue program, the pregnancy will not be covered because of the waiting periods imposed for the pre-existing condition. This is standard practice.

Business/industry exclusions also impede access. Mr. C was denied health insurance because of the type of business he runs—a small home and office cleaning service. When the carrier was challenged, they stated the reason for ineligibility was because of the hazards of working with chemical solutions, which were home cleaning products, on a day-to-day basis. These, incidentally, are the types of products that you use in your own homes, in your kitchens and bathrooms. Because he used them on a daily basis, he was excluded. I have many more horror stories that you can read in the written testimony.

I would just like to continue by saying that carrier terminations are also occurring of entire blocks of businesses on a national level. Most recently, Surecare, an Iowa HMO, terminated 17 small business subscribers and their dependence, and at this time are not offering conversion privileges to these people. They are out of insurance and on their own to cope with the problem.

Mr. H, an owner of an instructional material company, and presently enrolled with Surecare, has only two weeks left to find alternative coverage. Because he has a mild heart condition and is an older man, he fears he will not find another carrier.

The CHAIRMAN. I will give you a couple more minutes to wind up, if you would, Ms. Carroll.

Ms. CARROLL. OK. State insurance departments are receiving numerous complaints every day from small business owners regarding rating and underwriting practices. A major complaint, and one that underscores the problem, is from the small business person who has had significant rate increases every six months for two or three years, his claims are 37 percent of the premium he has paid, and his coverage is being terminated nonetheless.

Should insurance be available and affordable only to those who need it least? The industry is becoming increasingly selective about the risk it will enroll from the small group market. Although this may appear to be sound business practice, it results in an anti-small business policy, which is a major contributor to the problem of the uninsured in America.

Even commercial carriers are retreating from the small group insurance market. A recent market analysis listed 27 midsize commercial carriers that have left the group health insurance business. One reason they stated was they found better opportunities for profit elsewhere.

Obviously, the problem of health insurance coverage for the small business population is growing. Insurance companies and HMOs continue to abandon this market or restrict its underwriting. This is a national problem. State initiatives to resolve the problem of affordable accessible health insurance for the small business population are inadequate. It requires a Federal solution, like that proposed by Senator Kennedy. It takes courage and foresight to take action when a problem becomes a crisis. Senator Kennedy has recognized the magnitude of this situation.

It is approaching crisis proportions and can no longer be overlooked or ignored. Small business people recognize the need for a national solution to the national problem of unaffordable and inaccessible health insurance which is a major cause of the growing number of uninsured people in America today.

Thank you.

The CHAIRMAN. Thank you very much.

David Raine, owner of Raine and Son, Inc., a plumbing business, will be testifying in behalf of the Chamber of Commerce. We are glad to have you here this morning.

STATEMENT OF DAVID A. RAINE, OWNER, RAINE AND SON, INC., HYATTSVILLE, MD, REPRESENTING U.S. CHAMBER OF COMMERCE, ACCOMPANIED BY KAREN BERG BRIGHAM, MANAGER OF HEALTH CARE POLICY, U.S. CHAMBER OF COMMERCE

Mr. RAINE. Mr. Chairman and members of the committee, my name is David Raine. I am President of Raine and Son, Inc., a plumbing business incorporated a generation ago by my father.

I am a member of the Council of Small Business of the U.S. Chamber of Commerce and will be testifying on behalf of the Chamber today.

We commend the Chairman for the attention he has brought to this critical issue, and we are grateful to Senator Hatch for the leadership he has demonstrated in developing legislation to address the underlying problems of our health care system.

I must emphasize that we favor the Hatch approach and indeed, we strongly oppose S. 768.

I will focus my remarks on the challenges I have faced in providing health care coverage to my employees. My plumbing business now has 75 employees in two locations—Hyattsville, Maryland and an office on the Eastern Shore of Maryland in Ocean City.

From the beginning, we have always provided a health plan for our employees. We normally have paid for the total cost of insuring an individual employee, and we currently provide a plan that pays 100 percent of health costs, including hospitalization and prescriptions.

We are one of the few employers who maintains 100 percent coverage after the deductibles are satisfied. However, this is not without its problems.

We have changed insurance carriers several times because insurance companies tend to offer competitive rates the first year and then increase the rates significantly the second year. This situation drives us back into the market to look for a new carrier. Last year alone, our health insurance costs increased 35 percent; they year before, they increased 28 percent. Unfortunately, upon going back into the market, we found these rates still to be competitive.

The result is that we had to begin absorbing the costs—$42 more per employee per week—rather than hit our employees with a $40 to $50 increase in health insurance.

Right now, health insurance for a family at our company is $391 per month, up from $280 per month last year. Individual coverage is $111, up from about $80 last year.

Normally, we would pass this on to the employee, but changing demands in the work force compel us to continue our plan on its current basis in order to remain competitive.

Frankly, if we passed on these increases to our employees, we are afraid we would start losing them to employers with lower health plan costs. Of course, most other employers require some sort of cost-sharing, often 80/20 plans, but employees tend to look more at the money in their pockets at pay day rather than opportunity cost.

In 1982, our hospitalization insurance costs equalled 0.91 percent of our gross sales. In 1986, this figure grew to 1.75 percent. Last year, our hospitalization costs were 2.5 percent of our gross sales, which equals our net profit.

But we are an established business, and we have the financial strength to absorb the skyrocketing costs of health care. New businesses just starting may not be able to do this. Entrepreneurs may not open new businesses. The effect on new jobs in this country will most certainly be dramatic.

When our hospitalization costs equal our profit margin, the situation clearly is deteriorating. The added burden of Section 89 compliance has caused us to rethink where we should take our health plan.

Proposals such as mandated health coverage would only disrupt an already delicate situation. Overall, my labor costs will increase dramatically, forcing me to make difficult choices. Employers like me will be forced to rearrange costs wherever possible. I may have to cut other existing benefits. I may be forced to cut employee hours. I will surely have to pass on costs to my customers, as will producers of goods and services across-the-board. This will erode my ability to compete in an already very competitive market.

What I as an employer look for is an enlightened approach to solving the rampant problem of the uninsured. Policymakers who failed in their national health insurance drive cannot now burden small business by imposing broad mandates for health insurance. Small businesses employ 46 million people, or about half of those employed in the United States. Already more than half of the small business employers offer health care plans to employees.

Every year, we re-evaluate our benefit plans, and it is my sincere hope that our company will not be forced to take a step backward because of the short-sightedness of unrealistic lawmakers. The focus should be on containing health care costs. Therefore, more employers can afford health plan benefits. The market pressures in attracting qualified employees need to dictate benefit plans offered to employees—not the Federal Government.

For that reason, we commend Senator Hatch for developing a comprehensive proposal that is aimed at reducing health care costs and making it easier for businesses of all sizes to offer health care coverage.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Raine follows:]

PREPARED STATEMENT OF DAVID A. RAINE

Mr. Chairman and members of the Committee, my name is David A. Raine. I am president of Raine & Son, Inc., a plumbing business incorporated by my father in 1963. I am a member of the Council of Small Business of the U.S. Chamber of Commerce. I will be testifying on behalf of the Chamber today and am accompanied by Karen Berg Brigham, Manager of Health Care Policy for the Chamber.

We commend the Chairman for the attention he has brought to this critical issue. And we are grateful to Senator Hatch for the leadership he has demonstrated in developing legislation to address the underlying problems of our health care system. I must emphasize that we favor the Hatch approach, and, indeed, we strongly oppose S. 768.

The Chamber opposes federal or state government requirements mandating plan design or financing because they limit flexibility and raise costs. Mandating all employers to provide comprehensive health coverage to all employees does not take into consideration the factors that have prevented some businesses from providing coverage or the perverse consequences that it could have for many of the working poor. We support the present system of voluntary, nondiscriminatory, private-sector employee health care benefit plans that can vary in accordance with the needs of employers and employees.

We also support measures that build upon the employer-sponsored system by making coverage more affordable and available for small businesses and ensuring that public-sector programs meet the needs of the poor.

Raine & Son, Inc.

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Right now, health insurance for a family at our company is $391 per month, up from $280 per month last year. Individual coverage is $111, up from about $80 last year. Normally we would pass this on to the employee, but changing demands in the work force compel us to continue our plan on its current basis in order to remain competitive.

Frankly, if we passed on these increases to our employees, we are afraid we would start losing our employees to employers with lower health costs. Of course, most other employers require some cost sharing (often 80/20), but employees tend to look more at the money in their pockets rather than opportunity cost.

In 1982, our health insurance costs equalled 0.91 percent of our gross sales. In 1986, this figure grew to 1.75 percent. Last year, our hospitalization costs were 2.5 percent of our gross sales -- equal to our profit margin. But we are an established business and have the financial strength to absorb the skyrocketing costs of health care. New businesses may not be able to do this. Entrepreneurs may choose not to open new businesses. The effect on new jobs in this country will most certainly be dramatic.

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What I as an employer look for is an enlightened approach to solving this rampant problem of the uninsured. Policymakers who failed in their national health insurance drive cannot now burden small businesses by imposing broad mandates for health insurance. Small businesses employ 46 million people, or about half of those employed in the U. S. Already more than half of small business employers offer health care plans to employees.

Every year we reevaluate our benefit plans, and it is my sincere hope that our company will not be forced to take a step backward because of the shortsightedness of unrealistic lawmakers. The focus should be on containing health care costs so that even more employers can afford health plan benefits. The market pressures to attract qualified employees should determine benefits plans offered to employees -- not the federal government.

Overview of the Problem of the Uninsured

Much attention has been focused on the problem of the growing number of Americans who do not have health insurance. As many as 37 million Americans do not have coverage, and this clearly is cause for concern.

In order better to understand the problem of the uninsured, it is important to examine the demographic characteristics of this group and the factors that have prevented some companies from offering health care coverage.

The uninsured are not a homogenous group. The Employee Benefits Research Institute (EBRI) estimates that while 18 percent of the uninsured are non-working adults, approximately two-thirds of the uninsured have some connection to the work force (i.e., they are workers, spouses or dependents). Nearly three-quarters of the working uninsured earned less than $10,000 per year. But 8.4 million or 22.8 percent of the uninsured had family incomes of more than $30,000 per year.

Half of all uninsured workers work in firms with 1-24 employees, according to the Small Business Administration (SBA). As is true with most employee fringe benefits, the prevalence of health insurance benefits increases with firm size.

There are several factors -- primarily affordability and availability -- that have prevented some businesses from providing health insurance. One SBA study cited lack of sufficient profits and the high cost of health insurance as the primary reasons that small firms do not offer health care coverage.

For businesses like mine that do provide coverage, health care inflation is eroding profitability. Health care inflation has averaged more than twice the general inflation rate in the past five years. Last year, most employers were faced with double-digit inflation in the costs of their health plans. The reasons for this inflationary spiral are complex, but among the contributing factors are an aging population, wider availability of new technology and an explosion of medical malpractice suits that have caused some doctors to practice "defensive medicine," ordering tests and procedures that may not be necessary.

This latest wave of health care inflation has hit small businesses particularly hard. Health insurance premiums for small companies run 10-15 percent higher than those in large firms because there are fewer people among whom to spread risk and the administrative costs are higher for small groups. In addition, small business-dominated industries with lower coverage rates -- notably, services, retail trade and construction -- are characterized by low and uncertain profits and high employee turnover.

In addition, the Medicaid system is not meeting the health care needs of many of the poor. Differing state priorities and a growing elderly population with chronic care and nursing home needs have diluted the effect of this federal/state program originally designed to increase access to basic health care for the indigent. Approximately 32 percent of the uninsured population are poor -- defined as those with incomes below the federal poverty level. (The federal poverty line in 1988 was $9,690 for a family of three.) Currently, only 40 percent of Americans with incomes below the poverty line receive assistance from the Medicaid program.

Filling the gaps in coverage will require building upon the employer-sponsored system by making coverage more affordable and available for small businesses and ensuring that public-sector programs meet the needs of the poor.

Mandated Health Coverage: The Wrong Prescription

Those who support mandated benefits do not seem to realize that many businesses simply cannot afford the added burden of providing a generous array of heath care benefits. Health care coverage is less extensive among smaller firms, in part, because very often the quid pro quo for offering health care coverage is not hiring additional workers, or not offering some other important benefit or wage increase or, in the extreme, simply going out of business. In fact, the concern over mandated benefits made opposition to such mandates the number two priority at the 1986 White House Conference on Small Business.

Mr. Chairman, I know that you acknowledge the problems that small businesses have in providing health insurance to workers and have included several provisions in your legislation targeted at small businesses. But this legislation does little to address the greatest problem that small businesses (indeed all businesses) are facing in providing health care coverage -- rapidly rising costs. Indeed, mandating health coverage would add fuel to the inflationary health cost fire because of the limitations it places on cost containment and the increased utilization of the health care system that would result.

In addition, a mandated benefit approach could have a perverse impact on the very group that it targets. Statistics indicate that most of the uninsured are already on the fringes of the work force. The additional labor costs imposed by S. 768 could render many of the uninsured unemployable.

As renowned Princeton professor Uwe E. Reinhardt noted in a January 11, 1989 Wall Street Journal editorial, if small business employers are forced to shift the cost of mandated benefits back to employees in the form of unemployment or lower wages, "employer-mandated health insurance will end up hurting the very people it is intended to help."

The Chamber's Recommendations for Improving the Health Care System

The Chamber supports, as a long-term goal, a system of public and private insurance coverage that would assure universal financial access to appropriate health care. Even while the nation searches for means to achieve that long-term goal, the Chamber supports immediate action to lessen the number of uninsured through a mix of public and private initiatives. The Chamber's Board of Directors recently approved a policy statement embracing the following proposals:

o Medicaid should be expanded to address the needs of the poor and near-poor who do not have financial access to primary care coverage:

1. Assure basic Medicaid coverage to all Americans with incomes below the federal poverty level, restoring the original intent of this program and defining clearly the public sector's responsibility.

2. Allow persons with incomes between 100 and 150 percent of the federal poverty level to purchase, for a sliding-scale premium, primary care coverage through Medicaid.

3. Permit persons with incomes above the poverty level who have large medical expenses to "spend down" and become eligible to receive full Medicaid coverage once income is reduced to the federal poverty level.

4. To ease an individual's transition off welfare or Medicaid, provide states the option of paying Medicaid-eligible employees' share of premium and other costs when private employer-based coverage is available.

In recognition of state and federal budget constraints, the Chamber supports various options for phasing-in expanded Medicaid coverage, with the following priorities: mothers and children, with the youngest children receiving greatest priority; phase up medical eligibility by percentage of poverty level, beginning with the "poorest poor"; and primary care coverage.

o Individuals who are uninsurable because of medical problems should be able to purchase health insurance through state pools.

As many as one million Americans are unable to purchase private health insurance because they are substandard health risks. The Chamber supports federal legislation that would require establishment of state pools for uninsurable individuals, with losses financed by state general revenues or other broad-based funding. To date, 16 states have established such pools.

o Expanded voluntary coverage through the workplace should be promoted through incentives and removal of disincentives.

Approximately two-thirds of the uninsured population has some nexus to the workplace (i.e., they are workers, spouses or dependents). The Chamber is committed to finding ways to extend private, voluntary insurance coverage without producing job loss and supports the following specific proposals:

1. Self-employed persons and unincorporated firms should be given a 100 percent deduction for health benefits costs. Unincorporated firms are about half as likely as other companies to provide health care coverage to owners and workers. Currently, these firms may deduct only 25 percent of these costs, and even this deduction will lapse at the end of 1989.

2. Multiple Employer Trusts (METs) should be encouraged. METs are group arrangements formed to help small firms obtain health care coverage on a more cost-effective basis than such a firm might be able to achieve alone. Use of improved cost containment, quality and appropriateness methods in these programs can make them affordable to a larger cross section of employers. However, numerous federal and state regulatory impediments have discouraged the proliferation of these arrangements. If necessary, such impediments should be preempted by federal action.

3. For those public or private employers unable to join a MET for whatever reason, risk pools should be made available as a means of achieving lower group rates and to reduce administrative expenses. The formation of such pools might be undertaken by insurers acting together or might need state or federal support. Any losses from such pools should be shared fairly based on who benefits from the insurance pool mechanism.

4. State-level benefit mandates and barriers to managed care programs should be preempted. More than 640 specific state mandates now require insurers to include particular benefits in health plans (e.g., mental health or chiropractic coverage), which make insurance more costly to employers with insured plans. A study by the National Center for Policy Analysis estimates that as many as 9.3 million people -- 25 percent of the uninsured -- lack coverage because of state mandates. Another study found that one in five small companies that did not offer health insurance in 1985 would have done so if their state's mandates were eliminated.

In addition to the state benefit mandates, there is increasing legislative activity at the state level that undercuts cost-containment efforts by limiting managed care arrangements. For example, some measures would limit the formation of preferred provider arrangements or the provision of economic incentives to employees to select such arrangements. Such barriers to managed care should be removed by federal or state action.

5. Federal benefit mandates should be repealed or simplified for employers.

o The development of national medical practice standards to assure appropriate and effective care should be promoted.

A significant percentage of services delivered in the U.S. health care system are judged by researchers to be either inappropriate or ineffective. Further, research has shown wide variations in the use of procedures across different geographic regions with no apparent medical justification. The development of practice guidelines, review protocols and outcome-based assessments through a national effort led by physicians and scientists is the key to getting this degree of waste out of the system. Use of such standards with due care by physicians should carry with it protection from unwarranted malpractice claims.

Senator Hatch today has introduced legislation that includes several of these proposals, including the ERISA preemption for state benefit mandates, establishment of state uninsurable pools and development of treatment practice guidelines. We commend Senator Hatch for developing a proposal that is aimed at reducing health care costs and making it easier for businesses of all sizes to offer health care coverage.

Conclusion

As health care costs climb nationally, the issue of financial access to health care has become inextricably linked with the issues of costs and quality. These three issues must be dealt with in tandem in order to forge a consensus on a workable solution. Such an effort will require a partnership of the public and private sectors, with neither sector being asked to absorb financing burdens more appropriate to the other. The Chamber looks forward to working with the Committee to develop and implement a workable solution.

The CHAIRMAN. I would recognize the Senator from Hawaii, who has another important obligation, for an introduction of one of our witnesses.

Senator MATSUNAGA. Thank you very much, Mr. Chairman.

This is unusual, because I am now going to introduce a witness from the next panel, but I have got to go and open up the America Folk Life Festival activities on the Mall, and Hawaii is being featured this year, and I have got to be there.

So it is my pleasure, Mr. Chairman and members of the committee, to introduce to you Dr. John C. Lewin, who is director of the Hawaii State Department of Health.

Dr. Lewin was appointed to head our State Department of Health in 1986. The Department, founded by King Kamehameha III in 1850, was the second governmental health department to be established in the world and the first established among the various States of the Union, of course.

Dr. Lewin has seven years of experienced as a commissioned officer in the United States Public Health Service from 1972–79. During this time, he served in the Indian Health Service and became the first executive director and founder of the Navajo Division of Health Improvement Services, thus managing the Navajo Nation's first health department. From 1979–86, Dr. Lewin was engaged in the practice of medicine on the Island of Maui, Hawaii, and was both the medical director of Kula Hospital and the Chief of the Family Practice Section at Maui Memorial Hospital.

Today, we will hear from Dr. Lewin about the efforts in which he and others have been actively engaged to make Hawaii the first State to achieve universal health insurance coverage. These efforts build on a base provided by the Hawaii Prepaid Health Care Act, which was passed in 1974, and requires that each employer provide health care insurance to his or her employees. Through the Act, the State of Hawaii has reduced the percentage of those without health insurance from about 12 percent without hospital coverage and over 17 percent without medical coverage in 1971 to approximately 5 percent of our State's population in 1989.

Mr. Chairman, I understand that several provisions contained in S. 768 are based on the Hawaii Prepaid Health Care Act, particularly with regard to assisting small businesses in meeting their health care obligations.

As a cosponsor of S. 768, I regret that I will not be here to listen to Dr. Lewin, but I have his full written statement and will be sure to read that statement—and of course the statements of the other witnesses.

It certainly is my pleasure to introduce to you, Mr. Chairman and members of the committee, Dr. John Lewin.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Matsunaga.

We have learned a great deal from the Hawaii experience and from you. Hawaii is really unique among the States in addressing this issue a number of years ago. When we are asked about our various proposals, and we hear those talking about the sky falling in, we look to Hawaii as a very practical laboratory. They have effectively done what we are attempting to do, and have done it extremely effectively without the kinds of adverse conditions which have been suggested by our proposals. We understand that the health industry in Hawaii is the best in the country which is, I think, a pretty clear indication as to how effectively it is working.

We'll have a chance to hear from you, Dr. Lewin, in just a few moments. I have a few questions for this panel, and then we'll go to Panel II.

Let me go first to Kelly Buckland. You mentioned in your testimony that you have money in your budget for health insurance for your employees. How much is allocated?

Mr. BUCKLAND. Mr. Chairman and members of the committee, approximately 18 percent of their annual salary is for benefits, and that means that approximately $1,000 to $1,500 per year would be available to buy insurance.

The CHAIRMAN. For the individual.

Mr. BUCKLAND. Yes.

The CHAIRMAN. You also indicated the insurance companies denied your employees coverage. Did the companies deny all of your employees coverage, or were some of the employees offered health plans?

Mr. BUCKLAND. Mr. Chairman and members of the committee, they did offer coverage for some of my employees; however, did exclude any pre-existing conditions.

The CHAIRMAN. So they did offer it for some, but not for others; is that correct?

Mr. BUCKLAND. Yes—at least partial coverage for some.

The CHAIRMAN. Since the funding seems not to be a particular issue with your company because you at least have some funding for insurance, the problem is just that you are unable to find any company that will offer you and your employees coverage; is that it?

Mr. BUCKLAND. That's correct, Mr. Chairman.

The CHAIRMAN. As I understand, there are about 3.2 million uninsured disabled people in the country; 7 million who are employment-locked. Is that your general understanding?

Mr. BUCKLAND. That sounds fairly accurate to me, Mr. Chairman.

The CHAIRMAN. Do you find that the current situation that you are facing out in Idaho is repeated in other communities which have the Program for Independent Living—which I know is nationwide, actually.

Mr. BUCKLAND. I have not had an opportunity to explore that to the depth that I feel I could comment knowledgeably about it, but I would expect that anyone who employs people with disabilities would find that they'd have a hard time covering any pre-existing conditions.

The CHAIRMAN. Ms. Carroll, you have obviously seen the harsh realities of the small business insurance market several times over. One of the first cases you cited was an employee who left a small business for a large business in order to receive health insurance coverage. The practice of aggressive underwriting puts small business employers and employees at a distinct disadvantage when it comes to obtaining health care coverage; wouldn't you agree?

Ms. CARROLL. Yes. That I think is a national problem, too.

The **Chairman**. Several of the examples you mentioned suggest that the traditional practice of health insurance, insuring individuals against risk, is eroding particularly in the small business market. Could you comment on this?

Ms. **Carroll**. There is no level playing field amongst insurers when it comes to the small group market. Now they are looking to enroll the young and healthy without realizing that our population is getting older in general, and as you get older, you do get sicker. And most entrepreneurs are older. They are usually over 30, 35 years old by the time they start their own companies or at least have them underway.

The **Chairman**. This problem which you have identified, do you have a feeling—I guess you have already answered the question—that it is growing?

Ms. **Carroll**. Yes, I do. Fewer and fewer carriers are saying yes, we will offer to a small group, and more and more carriers are saying we no longer want to write groups under 25 lives.

The **Chairman**. Do you find in your consulting work with small businesses that they are seeking your services to try and find out about health insurance and that it is increasingly difficult for you to provide those kinds of services?

Ms. **Carroll**. I think it is increasingly difficult to provide the services because the carriers are dusting off their old underwriting guidelines. It is not that the people are looking for the insurance because they are any sicker than they were even five years ago, so the people themselves haven't changed; it is just what is available to them or what they can afford, especially in the last five years.

The **Chairman**. Mr. Raine, you say that your firm insures your employees, you pay 100 percent of the premium cost, you require no cost-sharing after the initial deductible, and that you have a generous plan that includes prescription drug coverage; is that correct?

Mr. **Raine**. That is correct.

The **Chairman**. How in the world do you conclude that having to provide minimum health benefits as defined in the bill is going to make your labor costs increase dramatically, since there is an equivalency test, and actuarial reviews have indicated that 97 percent of the businesses that are providing health insurance meet that equivalency test? If you are providing the prescription drug coverage, certainly you far exceed what is required under our program.

Mr. **Raine**. There are several aspects in your mandated program that we do not cover. One, for example, is well-baby care. We do have obstetric coverage for our employees, but after that we do not have well-baby care; that is up to the employee to pay for with the provider.

The cost for my company—I am in an area that most if not all companies do provide some sort of health insurance for their employees. My concern more than anything else is having the Federal Government dictate what benefits an employer must provide to its employees.

I feel, at least in this area, the market pressures of trying to attract employees and keep your current employees will keep our benefit plan above others that are in my trade.

My concern to you today is that if the Federal Government starts to mandate these benefits—it may be health insurance, it may become other areas—I feel the market pressures for employment and retaining your employees is much more important than having the Government dictate what benefits that employer must offer.

The CHAIRMAN. Well, are you satisfied that market pressures are holding the prices down?

Mr. RAINE. No, the market pressures at this point are not holding the prices down in the price of health care. That is where the focus needs to be, not in mandating broad health benefits across-the-board. The focus must be in containing health care costs so more employers like myself——

The CHAIRMAN. How do you suggest that that be done?

Mr. RAINE. I am not an expert in the health field. I am in a business——

The CHAIRMAN. Well, do you want the Federal Government involved in that?

Mr. RAINE. In containing health care costs?

The CHAIRMAN. Yes.

Mr. RAINE. I think it is important that both the Federal Government, State and local governments, and people who work with the U.S. Chamber of Commerce and other local organizations ban together to try to find a solution.

The CHAIRMAN. You don't mind the Federal Government being involved in trying to hold prices down, but you are opposed to them requiring a certain minimum health package; is that right?

Mr. RAINE. I think it is important for everybody to band together.

The CHAIRMAN. Your program provides physician coverage, does it?

Mr. RAINE. Other than well-care coverage.

The CHAIRMAN. And hospitalization?

Mr. RAINE. Yes.

The CHAIRMAN. And the tests, any kinds of diagnostic tests—does your program cover those?

Mr. RAINE. That's correct.

The CHAIRMAN. Do you provide any prenatal care?

Mr. RAINE. Yes, our plan covers prenatal.

The CHAIRMAN. Do you have any mental health provisions?

Mr. RAINE. Maryland mandates in the plans that there is some minimum mental health benefits.

The CHAIRMAN. Well, it is difficult for me to see, outside of the well-baby care, if you are providing the prescription drugs that you wouldn't meet the equivalency test. But are you saying that all of your competitors all have health insurance as well?

Mr. RAINE. In this area it is very prevalent.

The CHAIRMAN. Do you find instances where any of your competitors do not have insurance, and given the rise of your premiums, they are able to have a product that is less expensive or more competitive than yours?

Mr. RAINE. Some of our competitors, to the best of my knowledge, make the employees pay for a portion of their plan. We do not do that. Therefore I feel we can be more competitive when we are trying to draw employees into our business.

The CHAIRMAN. Do you think most of the small businesses in your area, outside of even the plumbing business, are providing health insurance now?

Mr. RAINE. I feel that in this demographic area, most employers are providing health care at this time.

The CHAIRMAN. We have 24 million Americans who are working for companies who are not getting it. Who do you think ends up paying for their health care when they get sick?

Mr. RAINE. Well, obviously, the answer to that is everybody ends up paying for it.

The CHAIRMAN. Do you think you are paying for some of that?

Mr. RAINE. I am sure my tax dollars are paying for some of that, and my health care costs, my premium costs.

The CHAIRMAN. Do you think that is fair, that you are paying for that, because you are conscientious—you have a very impressive program, and you are finding your premiums are going up 30 percent a year—do you think it is right that you are paying for that increased premium when other companies are not providing coverage for their employees?

Mr. RAINE. I feel there are many different types of approaches. My written statement does allude to some of these approaches that can be used to help cover the uninsured. There is not a perfect solution. I don't feel mandating benefits is a perfect solution. There are several other ways——

The CHAIRMAN. Well, you also talk about expanding the whole Medicaid program. How much is the Chamber willing to pay, or how much do they want to see the deficit increase by providing increased expansion in the Medicaid program for the poor and the near-poor? That is one of the proposals you have in here.

Mr. RAINE. That is one of the proposals that we have in there. I am not prepared—I am not an expert in the field—to answer that question on how much it would cost or how much they are willing to pay——

The CHAIRMAN. Well, I wasn't going to bother bringing it up, but you're the one who said there are other proposals in there, and I had the good fortune to read through your testimony, and you mentioned that as one of the alternatives to this kind of a program. So I was just interested in what the Chamber was prepared to support on that.

Mr. RAINE. I think Senator Hatch has an idea in his proposal on how to phase in Medicare and Medicaid costs that would be associated at first with the extremely poor people and then, on a sliding scale basis, on people who are close to the poverty level as defined.

The CHAIRMAN. The question is who is going to pick up the tab on it and how much the Chamber is willing to support for us to phase that in. We'll get back to that.

I'll just wind up at this point. You don't mind, as I understand, paying higher premiums because you have a very effective program and somebody else down the block does not, and you'll pay higher premiums. You don't mind seeing the continued escalation of those premiums? You don't think that that is unfair?

Mr. RAINE. No. I think that is a major problem is the escalating premiums that we have seen—over 50 percent in the last two years. The question is how long can my business continue to absorb these increasing costs. Therefore, my concern is more on containing these health care costs. I don't have the answers for how to contain these health care costs.

The CHAIRMAN. Do you ever think about dropping or cutting back on your program?

Mr. RAINE. Yes. As a matter of fact, last year we had several discussions on increasing our wages to cover the expense of health care and making it completely employee paid-for. We decided not to do that, again more because of the competitive nature of our employment industry, that it is very difficult to find qualified people, and you must offer very good benefit packages to attract quality people.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

When you say, Mr. Raine, that your employees don't pay for their health insurance, exactly what does that mean—they don't pay a premium each month?

Mr. RAINE. The employee does not pay for his portion. We do bill back as a deductible for people who are on family plans. Up until this year, where we have had to absorb some of these costs—and this is where we run into the problem with Section 89—some of our employees are getting more compensation as to what we are absorbing as far as the family plan costs.

Senator DURENBERGER. But there is no premium contribution. Some of them contribute on a deductible, or all of them pay some deductible, is that it?

Mr. RAINE. Our deductible amounts in our plan are $100 per employee, $300 per family.

Senator DURENBERGER. Thank you.

Thank you, Mr. Chairman. I think I have to put all my other questions in writing.

The CHAIRMAN. All right. I want to thank all of you very much.

Mr. Buckland, we are glad to have you here. We concluded our hearings yesterday on the Americans with Disabilities Act, and we are very hopeful that we will be able to get that legislation through our committee as well.

We want to thank you, Ms. Carroll, and take note of your father here. He has appeared before our committee on other occasions as a notable authority on these issues. We are glad to see it runs in the family, and we want to thank you.

Mr. Raine, we are glad to have you as well.

We'll go now to our second panel.

Dr. Lewin has been introduced; we'll have also Jane Ramshaw-Reed, an insurance agent with 17 years of experience in the insurance industry and a nationally-known specialist in the small business market. She has spoken and written extensively about this area and, as an agent, brings a unique perspective to the issue.

We will also hear from Lynn Etheredge, a nationally-known health policy analyst, who served as Chief of the Health Branch of the Office of Management and Budget and has testified frequently on health policy issues. He has worked as a consultant and advisor to health insurance companies and businesses and others concerned with health policy.

W. "Biff" Naylor is President of American Restaurant Services. He is testifying in behalf of the National Restaurant Association.

Ronald Sandmeyer Sr., is Chairman of Sandmeyer Steel Company and is testifying on behalf of the National Association of Manufacturers.

And Mark Merlis, who is from the Congressional Research Service, has recently finished an in-depth analysis of the small insurance market for CRS and is here to report on his very detailed and useful findings.

Mr. Merlis.

STATEMENT OF MARK MERLIS, CONGRESSIONAL RESEARCH SERVICE, WASHINGTON, DC

Mr. MERLIS. Thank you, Mr. Chairman.

I am Mark Merlis with the Congressional Research Service. I am happy to be here to talk very briefly today about some of the findings in our recent study, called "Insuring the Uninsured."

If I could offer a couple of cautions to begin with, first, the health insurance industry is very complex, and not everything I am saying applies to every sector of the industry. And second, health insurance is costly chiefly because health care is costly. Even if you can bring down the extra costs that small employers face, you are still talking about an expensive commodity.

What has happened to small employers can best be understood in terms of market fragmentation—a gradual move away from the old system of cross-subsidy in which low-risk groups helped pay for high-risk ones.

Now, every group is on its own, and insurers in the small group market are left competing to enroll the groups that present the most favorable or predictable risks. In deciding who they are going to accept and what they are going to charge, insurers look at characteristics of the firm and then sometimes move on to characteristics of the individual workers. Insurers may classify firms by the type of business they are in; they are trying to avoid seasonal workers or those that face occupational hazards, along with firms in a line of business that has a high failure rate.

The smallest groups, even if they pass all of those tests, may then face medical underwriting. The insurer looks at the medical condition of each employee, and if there are high-risk members in the group, the insurer has three choices: deny the whole group, cover the group but exclude the high-risk employees, or include the whole group but charge higher rates or impose pre-existing condition limits.

Because these practices can weed out the high-cost applicants, the actual cost of services for a small group can be lower than for a large one, but this is more than offset by higher administrative costs. The general reason is that you are spreading some of the fixed costs of writing a policy across a smaller number of participants, so the per capita costs wind up higher. But there are a couple of cost components that are especially high for small groups. One is the commission to the agent who sells the policy; another is the risk charge or the risk and profit charge added on to the rate, which tends to be much higher for small groups.

There are a couple of other factors that are often cited as raising costs. One is State-mandated benefit laws, which tend to fall more heavily on the smaller firms, but there is a lot of debate over just how much those mandates cost. The second factor is tax policy—unincorporated businesses do not get the same tax treatment for health insurance as corporations, so their after-tax cost for coverage may be a little higher.

In addition to higher initial premiums, small groups can face large rate increases after the first year. Partly, this is because of the underwriting. If you are covering only the healthy people, your costs are lower to begin with; but eventually they get sick, too, and your costs start to go up. One practice that appears to be growing is rate increases tied to an individual group's actual costs during a year. A small group with one high-cost member can face a dramatic increase in the next year.

One result of all this is that some of the low-risk groups are jumping from insurer to insurer, looking for better rates, while the renewal business may increasingly consist of high-risk groups that cannot find better rates, so there may be further fragmentation of the market.

While there are numerous proposals to make insurance more available to small firms, the most frequent involve some kind of pooling—voluntary associations or METs, maybe some kind of public initiative. The notion is that if you can bring a lot of little groups together into one big group, you can cut some of the costs.

There does seem to be some potential for cost-cutting. You might be able to cut out some of the marketing expense, for example. But some of the overhead is going to stay high because you are still dealing with a lot of little companies. It may be if the pool gets large enough that it can go deal with the private insurers and bargain for better rates. But what is not clear is whether you can achieve enough savings to bring in the groups that are presently uninsurable.

If the lower-risk pool members are asked to subsidize the higher-risk ones, then they are going to spin out of the pool into the private market where they can get better rates. So the pool may gradually be left with only a core of high-cost groups that are unattractive to the private market.

So far there are two ways that pools have dealt with this trend. The first is to replace the internal cross-subsidy that they have lost with an external subsidy—raised through some form of tax. This is what most of the State pools have been doing. The alternative is to hold down the rates by underwriting—excluding from the pool at least some of the highest-risk groups. A pool that does this may be able to provide cheaper insurance for the groups it accepts, but you are still going to have some groups excluded from the market.

Mr. Chairman, I would be happy to answer any questions.

The **Chairman**. Thank you very much.

[The prepared statement of Mr. Merlis follows:]

PREPARED STATEMENT OF MARK MERLIS

Thank you Mr. Chairman. I am Mark Merlis, a specialist in social legislation in the Education and Public Welfare Division of the Congressional Research Service (CRS). I am pleased to be here today to share with the Committee some of the findings of a recent CRS study entitled *Insuring the Uninsured: Options and Analysis*, which I co-authored with Beth Fuchs. This report is one of a series of three comprehensive reports on the subject of health insurance and the uninsured prepared by CRS in the last year.

Although our report covered a wide range of insurance issues, I am at your request focussing today on the question of availability of group health coverage for small employers. I will be discussing some barriers that smaller employers may face in providing health benefits to their workers, as well as some of the options for overcoming those barriers through voluntary pooling mechanisms, such as multiple employer trusts (METs) and similar arrangements.

Before turning to these questions, two preliminary qualifications are in order.

First, because of the dynamic and very complex nature of the existing insurance market, it is difficult to make generalizations about the way in which the health insurance industry operates. Some of the practices I will be describing may be more prevalent in some regions of the country, or in some sectors of the industry, than in others.

Second, health insurance is costly because health care is costly. I will be discussing some of the factors that make insurance more expensive for small groups than for larger ones, along with some of the proposals for reducing that cost differential. However, even if small employers could buy insurance at the same rates as larger ones, the costs might still be prohibitive for firms with limited profitability.

The Small Group Market

The current American private health insurance system has evolved gradually over the course of this century, largely in response to the dictates of a free market. One important trend in that evolution has been a gradual move away from cross-subsidization of the costs of health care coverage. In the 1930s the original Blue Cross plans, along with similar plans developed by providers or consumers of care, offered insurance at fixed rates to all purchasers. Under this "community rating system," low-risk individuals and groups subsidized the costs for the higher-risk segments of the insured population. The rise of competition from commercial insurance companies in the 1940s led to a crucial innovation: "experience rating" for large groups. Low-cost groups demanded that the rates they paid for coverage be related to the costs incurred for their group alone. The commercial insurers met this demand. Ultimately the Blues were obliged to follow their lead and to offer some form of experience rating to large groups. Some groups found that they had sufficient resources to drop out of the market altogether and self insure, further reducing the pool of firms seeking coverage in the community-rated market.

Thus the original "community" of insureds has been fragmented into discrete populations. Some employers can buy coverage readily at standard rates or can provide their own coverage. Others must pay higher rates or cannot find coverage at all because of insurance underwriting practices. To point out that these rating and underwriting practices have discouraged or prevented many small employers from offering coverage is not to cast judgment on insurers or on the large group purchasers who have shaped the products that insurers sell. Classification of risks is a fundamental concept of all types of insurance. The logic of a competitive insurance market has acted to reduce the degree of cross-subsidy in the cost of health insurance, as insurers compete for the business of the groups presenting the most favorable or predictable risks.

Underwriting and Related Practices

In considering what employer groups to accept and what premium rates to offer them, insurers consider characteristics of the entire group, such as the type of business in which it is engaged, as well as characteristics of individual members of the group that may predict their future need for health services.

Several characteristics of firms may lead some insurers to deny coverage or to offer coverage only with special restrictions or very high rates. Some groups experience seasonal employment. In this case, medical care utilization often peaks just before layoff, or dependents seek medical care just after the employee goes back to work. Seasonality is characteristic of such industries as restaurants, hotels, laundries, contractors, canneries and vacation resorts. Other small employers may be denied coverage because they are in industries that present a high risk of occupational illness or accidents, such as mining, logging, commercial fishing, oil exploration and explosives manufacturing. Finally, some companies may pose credit risks because they are in a line of business with a high failure rate. Different insurers use different criteria for classifying particular industries as ineligible for insurance or eligible only with restrictions. As a result, a company excluded by one insurer on the basis of industry classification may be able to find coverage from another source.

Small groups, regardless of the nature of their business, may face an additional barrier to coverage: medical underwriting. For groups of fewer than 10 or 15 workers, an insurer may require medical information about each employee. If some members of the group are determined to present high risks, the insurer may follow any of a number of courses:

- The whole group may be denied coverage;

- The insurer may offer coverage to the group only if the high risk employees are excluded;

- The insurer may permit the inclusion of these employees but increase rates to the entire group.

Some other limitations may apply even if the group is not determined to be especially high risk. The policy may exclude coverage for pre-existing conditions, problems that were already diagnosed at the time the policy took effect but that may not have been known to the insurer, or impose a waiting period before coverage begins. The insurer may offer coverage only on a "nonguarantee issue" basis, meaning that the insurer makes no guarantee that it will offer the same policy to the group when the contract expires. Finally, insurers may be concerned that, within the approved group, only employees who foresee a need for health care will actually participate in the plan. If this occurs, the higher cost enrollees will not be balanced by lower cost, healthier ones. For this reason, many small group policies require minimum participation levels. In the very smallest groups, the policy may stipulate that 100 percent of eligible workers must enroll. To achieve these participation levels, employers must limit the share of premiums paid by the employees themselves. Very small employers may be required by the terms of their policies to pay the entire premium.

Cost Factors

Small employers who clear all these hurdles and obtain health coverage will generally pay more than larger groups for an equivalent plan. While estimates vary, health insurance premiums for the smallest firms may average 10 to 15 percent more than premiums charged to larger businesses. This difference is generally not attributable to differences in the cost of benefits. Partly because of the underwriting practices described earlier, which may exclude high risk individuals or entire groups, claims cost can actually be lower for small firms. The savings in claims, however, are more than offset by higher administrative costs and other surcharges.

For the smallest plans (1 to 4 employees), these administrative expenses can equal as much as 40 percent of claims. They drop to 35 percent for groups of 5 to 9, 30 percent for groups of 10 to 19 and 25 percent for groups of 20 to 49. By comparison, total administrative expenses of the largest conventionally insured plans (10,000 and more employees) are 5.5 percent of claims. In self-funded plans, which are generally not an option for small employers, administrative costs can be as low as 2.5 percent of claims.

One reason for higher per capita administrative charges to small groups is that certain fixed costs, items of general overhead that are roughly the same for each policy, must be spread across a smaller number of enrollees. However, there are certain cost components that are especially likely to be higher for small groups. The first is the commission paid to the insurance agents or broker who sells the policy; this averages 8.4 percent of claims for a group of fewer than 5 enrollees, and less than 1 percent of claims for groups of 500 or more. A second is the "risk" or "risk and profit" charge, which includes both the insurer's profits and some cushion against unexpectedly high claims cost. The risk charge averages 8.5 percent for groups of fewer than 5, and drops to 3.5 percent or less for groups of 500 or more. The higher risk charge for a small group is imposed in part because costs for the group may be less predictable than for a larger one. Larger groups may also pay a lower risk charge because of their greater bargaining power.

In addition to administrative charges, two other cost factors are often cited as barriers to the purchase of health coverage by small businesses.

The first is the effect of State mandated benefit laws, which require insurers to cover certain types of services or services by certain types of providers, provide for continuation or conversion of group coverage, or mandate coverage of certain individuals, such as dependents. Under the Employee Retirement Income Security Act (ERISA), States may not regulate employers' health benefit plans but may regulate the terms of health policies sold by insurance companies. An employer that "self-insures," or pays employees' medical costs directly instead of buying a policy from an outside firm, is exempt from State regulation. An employer that purchases coverage from an insurance company must buy one of the policies that the insurer is permitted to sell in that particular State, and is therefore indirectly subject to State mandates.

There is considerable debate over the extent to which these mandates actually add to the cost of health insurance policies. Some studies have reported that State mandated benefits can account for as much as 17 percent of total premium cost. Critics of these studies note, however, that some of the benefits most frequently mandated by State laws (such as outpatient psychiatric care) are routinely offered even by self-insured firms that are not subject to the mandates. It is not always clear, then, that State mandates necessarily lead to more comprehensive or more expensive policies than would have been provided in an unregulated market. Still, some mandates may prevent insurers from offering products that might be more affordable for small employers, such as catastrophic plans.

The second cost factor often cited is the effect of current tax policy on unincorporated small businesses. The owners of sole proprietorships or partnerships may deduct from their income only 25 percent of the cost of insuring themselves and their families; if the same business were incorporated the whole cost would be deductible. This means that the after-tax cost of a health plan is higher for self-employed individuals. However, coverage of other employees and their dependents is a fully deductible business expense in both incorporated and unincorporated firms. The difference in tax incentives for the purchase of insurance applies only to coverage of the owner and his or her family. As the number of employees in a firm increases, then, the difference in after-tax costs for a health plan in incorporated and unincorporated firms diminishes. A change in current tax policy might be significant only for the very smallest businesses.

In addition to facing higher initial costs for coverage, small employers may find that their premiums increase rapidly after the first year of coverage. If a group is medically underwritten, it may start out with a healthy pool, since the group members with a known, immediate need for health services have been excluded. Over time, however, those left in the pool will gradually use medical care at greater rates. The cost of claims paid under the policy rises. Accordingly, many insurers raise the rates after the first year of the policy. (Some may offer, as an alternative, to re-underwrite the group, again separating the currently sick from the currently healthy.) There may also be cases in which insurers quote artifically low rates for the first year in order to gain new business.

One other rating practice that was once fairly rare in the small group market but now appears to be gaining currency is some form of group-specific rating, especially for years after the initial year of the policy. Experience rating, in which premiums are based on actual costs for the particular group, is still uncommon in the small group market. However, some insurers may classify small employers into broad ranges, or "tiers", by claim experience. A group with unexpectedly high costs during a year may be reclassed into a new, higher rate "tier."

Employers who present the best risks may respond to annual rate increases by seeking a new insurer who will offer a more affordable first year rate. As a result, while insurers are competing more vigorously for the groups that present more favorable risks, their renewal business may increasingly consist of higher risk groups unable to find a lower price. If this spiral continues indefinitely, the effect may be a further fragmentation of the market.

Pooling Arrangements

There are numerous proposals to make health insurance coverage more affordable for small businesses. Some of these proposals address the peripheral cost factors discussed earlier. For example, State mandated benefit laws might be overridden to allow insurers to sell low-cost, catastrophic plans. Or unincorporated small firms might be given the same tax advantages as corporations. Perhaps the most frequently raised proposals, however, involve the establishment of some form of pooling arrangement, in which many small firms are combined into one large group for insurance purposes. Some of these proposals involve voluntary associations such as multiple employer trusts (METs). These may function as joint purchasing arrangements for health insurance or may self-insure, as large single groups do. Alternative proposals include the establishment of a public or quasi-public entity that would sell insurance to small firms not reached by the commercial market.

It should be noted that, from the perspective of the insurance industry, small businesses are already pooled. While some groups (or individuals within those groups) may not be able to purchase insurance at all, those that are accepted are still often paying a common rate for their coverage, representing the average costs for the insurer's whole line of small group business. Proposals for a more formalized and explicit pooling arrangement rest on the assumption that a formal pool could include groups that would otherwise be excluded or could operate with administrative costs resembling those charged to larger employers.

While pooling does present some real possibility for administrative savings, the potential size of these savings is debated. Some components of administrative cost, such as commissions to agents or brokers, might be reduced or eliminated. Other costs, such as those for billing or member communication, might remain high simply because the pool was still dealing with many small clients. The potential for further savings may depend on how the pooling arrangement is structured. A public sector initiative could further reduce premium costs simply by forgoing part of the "risk and profit" charge. In so doing, however, it would be directly undercutting private sector competitors. A very large private pool might develop sufficient bargaining power to achieve the same effect, demanding reductions in risk charges comparable to those that very large single companies may receive. This is reported to have been the experience, for example, of the Council of Smaller Enterprises (COSE) in Ohio.

If pooling can in fact achieve some reduction in the cost of health insurance for small groups, the remaining question is whether these reductions would be sufficient to permit the inclusion of groups or members of groups presently deemed uninsurable by the commercial market. If the market continues to operate in the manner described earlier, the answer may be no. Lower-risk groups that might otherwise have participated in the pool might be offered more favorable rates by private insurers, leaving the pool consisting only of those groups less attractive to the private market. As rates are increased to deal with this unfavorable selection, there may be further migration of lower cost groups from the pool, resulting in yet another rate increase for those remaining.

There are two basic approaches for dealing with this trend and keeping the coverage affordable for the groups remaining in the pool. The first is to replace the lost cross-subsidy among groups with an external subsidy, funded through general public revenues or through a dedicated tax on insurers or providers of care. This has been the common approach in pools directed at individual purchasers of insurance, rather than small businesses. The alternative – one that has been adopted, for example, by COSE – is to adopt some of the underwriting practices used in the commercial market. Rates can be restrained by excluding the highest risk groups or members of groups. A pool adopting this approach may be able to provide more affordable coverage for the groups it accepts, but some firms would still be excluded from the insurance market.

Mr. Chairman, I would be happy to answer any questions.

The **Chairman**. Ms. Ramshaw-Reed.

STATEMENT OF JANE RAMSHAW-REED, HEALTH INSURANCE AGENT, RAMSHAW AND ASSOCIATES, SAN DIEGO, CA

Ms. **Ramshaw-Reed**. Good morning, Senator.

I have been asked to testify today about two issues: the state of the small employer group and individual insurance marketplace and the agent's role as the distribution system within that marketplace.

I think what is interesting, Senator, is that this is the first time that we are really addressing the soldier that is on the line—the insurance agent.

Yes, ladies and gentlemen, I am an insurance agent. I have been in the business 17 years and earn 100 percent of my income selling health insurance. My client base is very important to me, for they pay me by hiring me.

I believe access to health care coverage is a right of all Americans, and to that extent I think we also have to take a look at the present marketplace. I believe we should keep in mind the old adage: Shoot the messenger.

In Greek times, if a messenger brought good news, he was given rest and food. However, if he brought bad news, he was killed.

The soldier I am referring to are agents such as myself—and there are hundreds and thousands of them throughout the United States—that are in fact, unfortunately, very often delivering bad news—and we do get shot.

So to that extent, if I could, I'd like to give you perhaps our perspective, a little feeling of how we look at this particular marketplace.

We are insurance agents keep getting shot, and the reason why is the news. The public has a way of blaming the insurance companies, and of course the fallout is they blame us, the insurance agent. They say that the insurance companies are creating the problem.

May I tell you that the problem is really, I believe, created by you and I. The enemy, I believe, we have met, and we are looking at the enemy. You see, it is the consumer, it is you and me, the users of these benefits, that create the problem we are in.

Small business has a severe problem. The testimony so far has told you what that problem is. But may I tell you that for years, the small employer has said to me, every time they get a rate increase: "Put it out to market, Jane. I want to take a look at what is out there." And typically, they move the business. That is called "churning". And they have "churned" the business for the last four to five years, and what has happened is that our marketplace has responded by tightening when it comes to underwriting.

You see, when we now have a "churning" market in which a business may have had four carriers in the last five years, we are looking at never being able to establish an ongoing relationship, and they buy by cost, and they are constantly "churning".

So who is the real culprit in the process? Well, perhaps it is not just one effort. You know, we are talking about access to health care coverage here today. We are not really talking about the overall bigger problem, which is containing that cost. We have got to take care of one problem, and that is access, and that is what we are discussing.

As an agent, I would like to tell you that we are very committed to our clients. You know, our relationship goes on through years, throughout the changing of carriers, and that is what we are all about. We take care of claims, we take care of administrative problems, and in small business, believe me, every small businessman knows his insurance agent. He sees him often—very often, more often than he'd like to see him. But in the process, here we have an individual who is extremely valuable.

May I suggest to you that in fact the present marketplace is such that you cannot do without the agent. Now, I know you believe everyone is expendable. But you see, we are an important and unique piece of this puzzle, because we service the account. The first-month commission is considered sales commission. The second and consequential commissions are marked down as service commissions.

Do you know that an agent who does a good job retains his client; an agent who does not loses his client to another agent in the process on any month.

Consequently, what I am suggesting to you here is that it is a rather honest system. You see, I think a businessman will get extremely frustrated, and—you all know examples of this—if you had to deal with Government bureaucracy when it had to do with a subject that you had a lot of questions about, you see, the agent is there to answer those questions, but more importantly, to troubleshoot after that.

We have got a major problem, and I come in to a client, I hold up my hand and I ask, "Do you have any of the big five—cancer, diabetes, heart problems, AIDS, or pregnancy?" Any of the big five means at that point I am extremely crippled in finding you insurance.

Now, if you are healthy right now, I'm going to be able to find you insurance, both individual and group. But do you know what? If you presently have one of the big five, I will not be able to move your group. That is my problem. You will get a rate increase. You have a heart problem in the group. The other carriers are asking health questions, and they are not going to take the risk.

Now, unlike before, in small group all the way up to 25 lives, one to 25, there are three to five health questions asked on individual employee applications. It is further clarified by the employer answering these questions on the master application.

So you see, there are now truly underwriting questions, and we come back to the problem: Who created this in the first place? You see, the perspective from someone on the front line is perhaps it is the consumer who created the problem in the first place. And also, I am very aware of how important my role is to that consumer.

Thank you.

[The prepared statement of Ms. Ramshaw-Reed follows:]

PREPARED STATEMENT OF MS. RAMSHAW-REED

I have been asked to testify today about two issues. 1. The state of the small employer group and individual insurance marketplace and, 2. the agent's role as the distribution system within that marketplace.

Please allow me to introduce myself. I am Jane Ramshaw-Reed. I have been in the insurance business for 17 years. I earn 100 percent of my income from the sale of health insurance products. I speak to my industry's professional groups. I also speak to medical societies and senior citizen groups. I frequently appear on radio and television. I have published many articles in the periodicals of the insurance industry and I have worked for Blue Cross/Blue Shield, an HMO and a commercial carrier. I have brokered as a wholesaler for many insurance companies. I have acted as an employee benefit specialist for a large fire and casualty agency and I have owned my own insurance agency since 1980 that specializes in small groups and individuals. My background provides me with a perspective which I think is realistic.

I believe access to health care should be a right for all Americans. This has been considered a privilege in the past but today most consider it a right. In today's world, lack of health care coverage can be disastrous. Yet we know about 15 percent of Americans do not have that coverage. People without coverage fall into three categories presently: people who cannot afford coverage, the uninsurables, and those Americans that simply choose to not have coverage and hope nothing happens. In each case, the possibility of total financial ruin exists.

As I describe this present marketplace, I feel we should keep in mind the story of the messenger in Greek ancient history. If the messenger delivered good news then he was given good and rest. However, if he delivered bad news he was killed. Thus the adage, "shoot the messenger." We as insurance agents keep getting shot since, as you will see, the news is often bad. The public has a way of blaming the insurance companies for the problem. In fact, the insurance companies practices are an effect of the real problem which is cost. Today, however, we are addressing the issue of access to health care and not the larger problem of health care cost. I say we have met the enemy and it is you and I—the consumer of health care. We have the finest medical care in the world and we all pay for it in one form or another.

The small group market as discussed here—one to twenty-five employees—has been a one-way street for too long. The consumer has shot himself in the foot by constantly changing insurance carriers whenever he got a rate increase. This constant churning was available because of the highly competitive marketplace. We have seen the marketplace tighten because of this runaway inflation and the fact that companies are losing so much money. Therefore insurance carriers are leaving this marketplace in record numbers because of these high loses.

If you have a significant health problem, i.e., one of the big five: heart problems, cancer, diabetes, AIDS, pregnancy, I usually cannot get insurance coverage for you. The exception to this lack of coverage is being currently covered by a group contract at the time of the onset of the condition.

If you are a healthy individual, health insurance on an individual contract basis is certainly available. However, if you have any of the Big Five or even smaller risk items such as back problems, arthritis, allergies, etc., you can still get coverage but the conditions that you already have, the preexisting ones, will be excluded or ridered out for a period of time or indefinitely.

If you are a healthy small group and you have no major health problems in the group then your rate increases will be what the inflation rate is running. However, if you have one of the Big Five then not only do you get inflation plus usage charges but also I cannot move that group to another carrier. Today three to four health questions regarding the Big Five are asked on each individual employee application and further clarified on the master application that the employer signs. This ends the constant churning and replacement action that employers have been able to get by with in the past. You are now married to your present carrier if you have one of the Big Five—and they are married to you.

If you are a health group but you have more than 10 percent of your total group on COBRA Extension that is considered as bad as the Bib Five since the concept is that only unhealthy individuals take COBRA. Right or wrong—there will be no movement for the group.

If you are a particular industry that is considered high risk, i.e.: doctors, attorneys, restaurants, nuclear waste disposal company, etc., again moving business is not possible and getting new coverage today is virtually impossible.

At this point in time, the picture of insurance coverage and rates is rather bleak for the individual and small business consumer who has created this problem in the first place. The bright spot in the picture is the insurance agent.

The agent is a unique piece in the puzzle of health insurance. Most people do not understand health insurance and do rely on their agent for assistance. The agent represents and services the insured. The insurance product is not bought casually through the mail today. The product is far too confusing.

When claims occur the agent becomes the advocate of his client. He finds out what is happening and acts as a communicator between the claim department (which usually speaks a strange language called claims processing) and translates to the insured.

Agents conduct employee meetings to foster understanding of their employee benefits and a form of real communication is created.

I have many examples of clients contacting me and my fellow insurance agents during crisis for assistance because a real trust has been established. This relationship usually lasts for years through all the changes of carriers. The agent truly cares and their work actually takes place with the servicing of the account each and every month.

This relationship is one to not be ignored nor to casually be done away with. The small employer knows his health agent and sees him often.

To eliminate the agent as the distribution system I believe will create a problem in getting this product to the consumer. Health insurance has always been a mystery to be explained and worked by servicing. Also, if an agent does not do his job then he loses his client to another agent. It's a rather honest system and one that works.

Consider the small businessman and his frustration if he does not have an advocate on his behalf in this one arena. It is at best difficult to work out problems and communicate with government bureaucracy.

Don't shoot the messenger in this case. Instead keep this valuable asset to the entire system and presently and in the future small business and individuals will thank you.

The CHAIRMAN. What were the three questions you said they asked?

Ms. RAMSHAW-REED. There were five—heart problems, cancer, diabetes, AIDS and pregnancy.

The CHAIRMAN. And that is asked of each of the employees, is that correct?

Ms. RAMSHAW-REED. Between the three questions, overall they are now asking about AIDS, and are you pregnant, and then do you have any claim that was over $5,000 in the last year; that tends to catch all the rest.

The CHAIRMAN. Thank you.

Dr. Lewin.

STATEMENT OF DR. JOHN C. LEWIN, DIRECTOR, HAWAII STATE DEPARTMENT OF HEALTH, HONOLULU, HI

Dr. LEWIN. Thank you, Senator Kennedy. I really appreciate being afforded the opportunity to come and address this body and also to support the concept in S. 768, Basic Health Benefits for All Americans Act.

In doing so, I'd like to share with you some of the successes we have realized in Hawaii along similar lines.

Certainly, when one looks at health and health care, there are differences. In a highly-technological Nation like the United States, health and health care are not directly related. Health is primarily responsibility in terms of lifestyle change which would probably most significantly improve our health status, with the priority of individuals more important than families, more important than communities, businesses, and government.

But when we look at health care and basic health care, certainly, business and government are primarily involved as partners to assist individuals, families and communities.

I think it is appalling that of the major industrialized nations of the world, only two lack a national health plan and program—the United States, and of course, we are in great company with South Africa. When we look at health care systems and health status, there really is a great deal of intervention needed for those who lack health care.

The excitement I am here to share with you today is that as of March of 1990, we have completed the last piece of a three-part program and will have achieved universal access to health insurance for all of the citizens in Hawaii. This has been accomplished by these three programs, the first of which is the Prepaid Health Care Act, which was passed in 1974, implemented in 1978. This program requires employers to provide health insurance for all employees, even down to one employee—and there are some exemptions I will go into. But 88 percent of Hawaii's present population has health insurance through this mechanism, employees and their dependents.

Medicaid covers 7 percent of our population in Hawaii, and the final 5 percent, so-called "gap group", are being covered by the mechanism of the new State Health Insurance Program passed in this year's legislature, the final step in that universal coverage program.

The Hawaii Prepaid Health Care Act really was landmark legislation. Most of America seems not to want to know that it has existed for ten years. All employees are covered, as I said before, and it is possible because of Federal ERISA legislation exempting Hawaii from ERISA that we were able to proceed.

I think it is important to recognize that all employers were required in 1978 to participate, but in 1981, one national employer who came to Hawaii challenged the law and successfully, for at least a two-year period, overturned the original Act, leaving a window of opportunity, so to speak, for businesses to exit from this requirement that was enacted in 1978.

The health insurance people in Hawaii have very good information to show that businesses did not exit from the program during that window of opportunity, in fact stayed with it and had gotten used to the fact that it really was a benefit. But the ERISA exemption is something that is important to us, and we recommend that when any national health plan is enacted that such exemption be permitted to States which go beyond the basic requirements of a national health plan.

I think Senator Matsunaga mentioned that 17 percent of our population was in essence uninsured for medical benefits before the Prepaid Health Care Act, and it went down to 5 percent after the Act was implemented.

It is broad coverage. The law provides for a ceiling cost for the employee of about 1.5 percent of total income, which is the maximum the employee needs to pay out. What this results in is that if you average it out today, Senator, the cost of the health insurance programs for employees range from about 40 to 45 percent of the total cost of the premium the employee pays. The employer pays about 55 to 60 percent.

I think that if we apply the actuarial equivalency test, however, to S. 768, there would be a good comparison. The reason the employee pays a greater portion in Hawaii is that it is a much expanded benefit plan. So I think there is a fairly good comparison.

If you want to look at the rates in Hawaii right now, the average individual goes $85 to $100 per month; family coverage including the individual would be $185 to $200 per month of which, of course, the employee pays half, the employer pays the other 60 percent or so.

There is an employer hardship provision in the program, which makes it possible for an employer to get a subsidy from the State—but here is another point for small business. In the ten years, only four companies have really applied for that subsidy provision.

There is no evidence that small business has been destroyed by this Prepaid Health Care Act in Hawaii, and that is because we require all businesses to participate. It is also because we don't really have commercial insurers in Hawaii. We have two main insurance companies providing 95 percent of the coverage, and for companies less than 50 employees, it is a community-wide kind of risk assessment rather than experiential. That is the reason we are able to keep rates low.

We do not have a big bureaucracy. I want to dispel that myth. Three employees were added to our Department of Labor, and in ten years we have covered 88 percent of the people. We have combined it with our Department of Labor's industrial accident compensation staff and so forth.

Medicaid is a broad program in Hawaii, and that is important. But the SHIP program, the new health insurance program, is covering the "gap group", which consists of the unemployed, people who are less than 20 hours a week who are not in the Prepaid Health Care Act eligibility, some few depends, but very few dependents, of those employed. Most dependents are covered in the Prepaid Health Care Act, more than 90 percent. Students and self-employed are also in the "gap group".

This final step will have a policy cost of about $700 a year, and that is because it is mostly a medical/outpatient kind of coverage—prevention, mammograms, PAP smears, immunizations, prenatal care, fitness exams and so forth will be primary in this program. Inpatient coverage for the "gap group" is already into our health insurance rates. We deny nobody needed inpatient care in Hawaii. So in essence, business is already paying for inpatient care, and we are therefore going to cover only the outpatient costs, and insurance companies and businesses are very happy. There will be no business charge for this new program. It is a State-underwritten program. Health insurance companies will provide the care. Private medical care system actually implements it. Simple sign-up, no new bureaucracy. I think it is quite exciting.

I am grateful to have the opportunity to testify about Hawaii's achievements, and I am very, very grateful for the activity of your proposed S. 768, which would offer us a national health plan with some minimum and basic benefits which are sorely needed.

I am glad also to dispel the myths that I continuously hear about Hawaii. Hawaii is in fact the "health State", the "international health and wellness capital", in a way, because we have the greatest longevity, the lowest incidence of heart attacks, lowest overall incidence of cancer, lowest incidence of emphysema, lowest average length of stay in hospitals, lowest number of hospital beds per capita, et cetera.

But it is a myth to think that because we have 50 percent Asian-Americans that that is why our health status is so high. Asian-Americans, one they adopt American lifestyle, end up with a very similar kind of morbidity and mortality pattern to the rest of America.

Our businesses in Hawaii are very similar in numbers of employees and so forth to businesses in other States. Hawaiians have the poorest health status of any ethnic group in the United States of America. They are almost 20 percent of our population. We have health problems, we have drug abuse, we have urbanization. We are not without the problems of the rest of America. It is our commitment to prevention and basic health care, Senator, that really is paying off, and business recognizes that it is paying off. We have an increased bureaucracy, and health care costs are low.

It has been a privilege to share the experience. Just as I close, the interesting point to me is that we ~~in~~ America spend almost—we are moving toward 12 percent of our GNP for health care costs, whereas 6 percent is our military budget, 6 percent is our education budget. In Japan, it is the opposite—12 percent on education, 6 percent on health care.

I think America needs to take some important steps, and I believe that basic health care benefits are going to lead us in the right direction.

The philosophy is really in this case that we are supporting something that goes beyond what I know to be real economic benefits to business and to the Nation to provide basic health benefits. It goes into a philosophy, and our philosophy in Hawaii is that health, that optimal balance of physical, mental, social, and environmental well-being is a right of all citizens and a responsibility which must be shared by all.

The time has come for America to establish a basic health benefits program. We must do this on behalf not only of our economy and our national health status but obviously on behalf of our human dignity.

Thank you.

The CHAIRMAN. Thank you.

What are your premiums? How much do they average going up in the last few years?

Dr. LEWIN. Well, the monthly premium costs are going up to about $100 from about $85 per month on the average for an individual. And if you throw in a family—family coverage in our State is the same whether you have one extra person or 20 extra people—that averages $185 a month. The total, if you look at the health insurance industry's estimated cost per year per person, in the HMO Kaiser Permanente program, it is a little less than $1,000 a year for everything—we are talking cancer chemotherapy, AIDS therapy, whatever is thrown in there—everything but long-term care. And for Blue Cross/Blue Shield, which is the HMSA company, it is about $1,600 to $1,700 a year. So it ranges in that range.

Our new gap program is going to come in at $700 because we are going to throw in inpatient benefits but we are already paying for it as a society. So it is mainly going to be funding medical care, outpatient, prevention.

The **Chairman**. Thank you.

[The prepared statement of Dr. Lewin (with an attached publication) follows:]

PREPARED STATEMENT OF JOHN C. LEWIN, M.D.

It is my pleasure to be here today to testify in in favor of the Basic Health Benefits for All Americans Act and to describe the success of our state with a similar plan. Our state believes that basic health care is needed for every person. Every member of our community shares in the obligation to ensure access to health care for all. The individual, through preventive health practices and purchase of insurance; business, through employment-based health benefits and a safe workplace; and government, through programs to take care of the disadvantaged, all share in this common, necessary effort. It is, therefore, with significant excitement that as of March, 1990--just nine months from now--Hawaii will have become the first of our fifty United States to make universal access to health care benefits a reality!

This accomplishment in Hawaii is based upon three major programs: first, the Prepaid Health Care Act of 1974, which mandates benefits to employees and strongly promotes coverage to their dependents----it presently covers 88% of our population; second, the state's Medicaid program which used federal and state funds to guarantee access to care for the 7% of the population at the bottom rung of the economic ladder; and third, our new State Health Insurance Program (SHIP), which will provide access to basic health care services for the remaining 5% of the population which is ineligible for either Prepaid Health Care or Medicaid.

Hawaii's Prepaid Health Care Act was passed in 1974, and actually implemented in 1978. This Act, which requires that each employer provide health care insurance to his/her employees, is landmark legislation. This program has been made possible by its exemption from the provisions of ERISA by federal legislation. The exemption is extremely important to our efforts. We would recommend continuation of such exemptions in any national health care legislation to allow states to deal effectively, as believe we have, with the economics of their own health care system. Through the Prepaid Health Care Act, Hawaii has reduced the percentages of those without health insurance from about 12% without hospital coverage, and over 17% without outpatient medical coverage in 1974, to approximately 5% of our state's population in 1989. The people covered by this mandated health care insurance possess a broad comprehensive coverage that provides for adequate hospitalization and outpatient services at reasonable costs that are shared by both the employer and the employee.

The law sets a ceiling on the portion of the employee's share of cost which must not to exceed 1.5% of employee income. I must point out that the Hawaii benefits plan is far more comprehensive than the basic benefits proposed in the Basic Health Benefits for All Americans Act. Thus, the employee's share of cost is about 40-45% and the employer's share averages about 55-60% of premium costs. The average monthly premium varies between $85-100 for a individual and about $185-$200 for individual plus family dependents of ANY number. The estimated annual average costs of coverage to the insurer under this plan varies between about $1000 per year to $1700 per year per individual employee. If we applied a comparison of costs between Hawaii Prepaid Health Care and the proposed Basic Benefits for All Americans by actuarial equivalency testing, the employee's cost share would likely be similar on a benefit by by benefit basis. In other words, Hawaii's higher employee cost share is based on inclusion of many additional benefits.

Further, under provisions of our law, employers demonstrating significant financial hardship in meeting their share of costs may file for state subsidy in a manner similar to your proposed Bill. However, in our ten years of experience with this law in Hawaii, there have been only four small businesses to actually apply for this subsidy!

Thus, there is no overwhelming evidence that our Prepaid health care costs have significantly adversely impacted employers. By requiring ALL to provide health insurance, the law ensures a level ground for fair competition. By helping to maintain a healthy workforce, it indirectly improves productivity. Some minor adverse impacts have, however, resulted from the wording of Hawaii's ERISA exemption, which does not allow for the Act to be significantly amended. As such, the exemption prevents changes in the Act which might help employers to contain costs.

One other significant reason why employer costs are within reason in Hawaii is that we have almost no commercial insurance carrier coverage and more than 95% of the insured are covered by only two companies. These companies use a community rating system for grouped small businesses of less than 50 employees to pool risk statewide and keep rates low.

To dispell a myth, Hawaii Prepaid Health Care has NOT resulted in the predicted expansion of bureaucracy---only three new staff were added to manage the program, mainly because it was linked with the existing state worker's compensation and temporary disability insurance programs and staff in our Department of Labor. Thus, the program has been inexpensive for the state to administer, and very effective in improving the health status of Hawaii, and Attachment 1 hereto will explain many more details of this program. Suffice it to say that this program has been operating for ten years effectively and comprehensively insures 88% of the population today.

Our second line of defense, Hawaii's Medicaid program, is a relatively generous one by national standards. The program, administered by our state's Department of Human Services, provides for 67,000 recipients with a total budget of over $250 million. While some asset limitations are in place, Medicaid is provided to persons with an income of below 62.5% of poverty. OBRA amendments have been utilized by the state to provide prenatal and infant care to women and children up to 185% of poverty. Waivers have also broadened the program to additional services for special populations such as the elderly, the developmentally disabled, persons with AIDS, and others at risk for institutionalization.

While the previously discussed systems of Prepaid Health Care and Medicaid covers 95% of Hawaii's population, there are gaps brought about by exclusions in the law and inflation, which has gradually moved the poor above the Medicaid poverty level. These gaps consist of: 1) unemployed workers, 2) part-time employed workers under 20 hours a week, 3) workers in certain seasonal occupations, 4) spouses and children of low-income workers who elect not to choose family coverage (although this population is small and an estimated 90% of the employed choose the family coverage option in Prepaid Health care), 5) students, 6) self-employed persons and members of family businesses, and 7) real estate and insurance sales persons paid solely by commission. Together, we estimate that these "gap groups" constitute approximately 50,000 persons (5% of our state's population) of whom only an estimated 30,000 are truly medically indigent. The others have the resources to purchase insurance but elect to take the risk of paying out of pocket for medical expenses..

Hawaii has addressed the gap group in the State Health Insurance Program (SHIP), the latest and exciting "final step" legislation introduced during our 1989 legislative session. This legislation provides funding and authorization for a preventive primary care insurance program for those who do not have access to Prepaid Health Care or Medicaid.. Mandated health care benefits have made such an initiative possible and fiscally within reach.

With this final piece of our overall health insurance system we have achieved our goal of Universal Access to Health Care. The benefits will include outpatient, preventive, and appropriate emergency services, laboratory and some pharmacy benefits, but only a small amount of inpatient care---probably 10 to 14 days per year---and does not cover catastrophic care, dialysis, or cancer chemotherapy, for example. Since we at present deny no person necessary inpatient benefits in Hawaii, and these cost are factored into existing insurance rates as "uncompensated hospital care", our average policy cost is geared to the costs of regular medical care at about $700 per person per year. There is no cost to business. The state will underwrite most of the cost--or all the cost for those just above the medicaid threshold--and will subsidize costs through a sliding fee schedule and some form of co-payments. Our health insurance companies will administer the program, and our private medical care system will deliver the care---again no new bureaucracy. We are presently in the process of developing the actuarial analyses, the benefit and fee schedules, program services, and eligibility requirements. The program will be operational in March, 1990, and funding is available for all the medically indigent in the gap group. This is not a pilot program, but a statewide commitment to basic health care benefits for all those who presently lack access to insurance.

This gap program (SHIP) is similar to the Basic Health Benefits for All Americans benefits and, thus, will not be as complete as those offered through other programs. It will offer Pap smears, diagnostic mammograms, immunizations, prenatal care, and fitness-oriented physical examinations. The focus, then, is a preventive, primary care, and "managed care" orientation designed to keep people well rather than investing in insurance for extended inpatient benefits. Signing up for this program will be based on a short form and a simple record of the previous year's income tax return. Attachment 2 is the initial position paper which helped create the recently passed legislation.

With the State Health Insurance Program in place, we that we will have addressed the gaps in our state's system and now look forward to working with the federal government and our fellow states to develop similar models elsewhere.

Mister Chairman and Members of the Committee, I am truly grateful to have been afforded with the opportunity to appear before you and testify regarding both the auspicious events in Hawaii, and the exciting potential for national health progress you are discussing here. It is important that I not fail to emphasize that Hawaii has the highest health status of any of the United States. We have the greatest longevity of any state; the lowest incidence of heart attacks and ischemic disease, cancer, emphysema ans chronic lung disease of any state. Our per capita hospital utilization rates and average length of inpatient stay are among the lowest in America. We may in fact be rightly considered to be the health and wellness capital of the World.

But do not please be deceived by the many "myths" about Hawaii that prevent others from considering our accomplishments as applicable elsewhere. Yes, our population is more than 50% of Asian ancestry, but the health statistics of Asian Americans parallel national norms as they incorporate American lifestyles. Business in Hawaii and business costs are far more similar to the mainland than different. Then also, the Hawaiian people are 18% of our population who unfortunately have the worst health status of any ethnic group in the United States. Drugs, alcohol abuse, AIDS, urbanization and related stress on families are challenges in Hawaii these days, too.

Yet, our commitment to prevention and public health does impact on health care costs positively. We have not seen the predicted administrative costs to our Prepaid Health Care Act and our small businesses have survived under its impact----in fact our health care costs are quite low by comparison to other states.

So, Mr. Chairman, on behalf of our Governor, our Legislature, our the Department of Health and our public, it has been a privilege to support your efforts to provide basic health benefits for all Americans by sharing Hawaii's experience. The philosophy and intent behind these efforts goes beyond just the economic practicality and benefit to business which will most certainly result from extending basic health benefits to all, despite the doubts of those incapacitated by fiscal fears of such action: our intent here has to do with the health of our nation.

The Hawaii Department of Health philosophy is as follows: Health, that optimal balance of physical, mental, social, and environmental well-being, is a right of all people, and a responsibility which must be shared by all--- individuals, families, communities, businesses, and government. The time has come for America to assume the responsibility of assuring basic health care benefits as a right of all citizens. We must do this on behalf of our economy, our national health status, and our human dignity.

STATE OF HAWAII
DEPARTMENT OF HEALTH
DIRECTOR'S OFFICE

Universal Primary and Preventive Health Care for Hawaii

INTRODUCTION

Access to primary and preventive health care is of vital importance to both individual and public health. In Hawaii, as well as across the United States, the primary vehicle for providing economic access to health care is health insurance. Health insurance cushions the effects of high health costs by spreading costs over the term of the insurance policy as well as across the entire insured population.

Persons not able, for one reason or another, to purchase or otherwise acquire insurance, often find themselves unable to access care. Such lack of access often causes delay in seeking treatment which results in a more serious, complicated illness. When treatment is finally undertaken, it is more expensive. The individual treated is then beset by higher costs than if early treatment were sought.

Not only does this negatively impact on the individual, additional costs impact on providers, and ultimately, the entire society. Those not covered by insurance who are unable to pay the costs of care either default on payments, or are able to pay only part of the costs of care. These unpaid costs, borne by providers, are termed "uncompensated care." Uncompensated care is sometimes subsidized by government, but more often its costs are "shifted" to the insurance pool, through higher charges to insurance companies by the providers. These higher costs are ultimately borne by the entire pool of persons purchasing insurance.

While those uninsured who are able to pay do not cause a public health problem, the uninsured "gap group" of those unable to pay do impact on the public health. For this reason, the federal government introduced the Medicare program for the elderly (often eliminated from employer-based insurance plans by retirement) and in partnership with the states, the Medicaid program, for the medically indigent. Both programs have been of immense benefit in making health care accessible. However, while most Americans are covered by these plans or private employer-based health insurance plans, significant numbers fall into the "gap group"--individuals and families often employed at low-income levels whose income is too high for Medicaid yet who for various reasons do not have access to employer-based health plans.

THE "GAP GROUP" NATIONALLY

A number of recent studies have documented a large "gap group" throughout the United States. In 1983, the Robert Wood Johnson Foundation estimated that some 35 million Americans lacked health insurance. A more recent data compilation by the Current Population Survey, U.S. Census, places the number at 17.4% of the U.S. population. While some of those included in this total have incomes sufficient to provide for their major health care costs, approximately half do not. Predominant among these persons are the unemployed, women, children, minorities, students, some of the elderly, low-income workers, and workers in seasonal industries and self-employed persons.

THE "GAP GROUP" IN HAWAII

Hawaii has enjoyed some respite from the severity of the problem nationally, due to its prepaid health care program. Prepaid Health Care mandates that employers in the State provide health care coverage to most categories of employees. This incorporates coverage of some categories of employees left uncovered in most of other states. This is evidenced by research results. In 1979, the Department of Health, through its Health Surveillance Program, surveyed 4,000 families to ascertain health care expenditures. The survey revealed that only 3.9% of this representative sample lacked some form of public or private health care coverage. After reviewing the situation in 1987 and 1988, in response to the Health Functional Plan and two legislative resolutions, the Department concluded that approximately 5% of Hawaii's population, or about 50,000 people, lacked health care coverage. While the figure might be as high as 7% or as low as 3% given the limited ability to gather data, a 5% figure was selected as a reasonable estimation of the uninsured population.

These studies further suggested the major subgroups in which this lack of coverage is prevalent:

1. The Unemployed

Of the uninsured persons located in the 1988 survey of Oahu adults, over 30% were unemployed. This would not include children (and spouses) of unemployed persons. Since prepaid health care is employer-based, the unemployed are not covered by the law.

2. Women

Spouses in single worker, low-income families, and elderly women not qualifying for Medicare are not required to be covered under prepaid health care as dependents. Low-income workers might elect not to cover families as there is often no employer subsidy of family coverage required under the Act. The survey noted above showed that over 50% of the uninsured adults were women.

3. Part-Time Workers

Prepaid health care specifically excludes persons employed for less than 20 hours a week. It is expected that this class of worker makes up a sizeable portion of the uninsured.

4. Children

As noted above, while employers are required under prepaid health care to cover their workers, they are not required to subsidize coverage for worker's families.

Families of low-income workers are thus often uncovered. Similarly, the families of part-time workers would be at risk.

Preliminary results of a Departmental survey of the public schools shows that at least 5% of public school students do not have insurance (see Table A). Since the response rate to the survey was 65%, the 8,400 students identified might not be the only uninsured in the system. The survey also had some 13,000 responses which were ambiguous. It is thus likely that the total of uninsured students is somewhat higher than the number counted. Nonetheless, trends indicate schools in predominantly "blue collar" (working poor) areas seem to have more uninsured children, or might be êxpected, since "indigent" families are eligible for Medicaid. Further follow-up study of the data is warranted to more accurately ascertain actual levels of the uninsured in the public school population. The Department is also studying the private school population in conjunction with the HMSA (Hawaii Medical Service Association) Foundation. Preliminary results are expected soon.

TABLE A

School District	Percentage Uninsured
Honolulu	5%
Windward	4%
Central	2%
Leeward	5%
Hawaii	6%
Maui	7%
Kauai	11%

5. Self-Employed Persons, Seasonal Workers & Students

This category of persons and their families are not covered by prepaid health care provisions.

6. Immigrants

As immigrants frequently find themselves in many of the above categories in low-paying situations as a group, it is expected that they would be at risk of lacking insurance.

7. Neighbor Island Residents

Nationally, persons in rural areas have lower rates of insurance coverage than residents of urban or suburban areas. This would seem to also be true in Hawaii as the public school data shows higher rates for Hawaii, Maui and

Kauai than for school districts on Oahu. This finding is supported by data from the Department's 1979 study which shows rates of 3.6% for Hawaii, 6.0% for Maui, and 5.7% for Kauai as opposed to the 3.6% on Oahu.

As can be noted above, the uninsured in Hawaii is a diverse population. Moreover, being uninsured is not necessarily preventing persons from accessing health care. National data, and data from states like Washington and Utah, suggest that between 40 to 60% of the uninsured population are able to cover at least the costs of basic health care. Projecting this on our figure of 50,000 persons, the Department estimated that about 30,000 persons lack both insurance and the resources to assure basic health care.

POLICY CONCERNS

The prepaid health care program administered by Hawaii's Department of Labor and Industrial Relations is the only legislation of its kind in the nation. It mandates insurance coverage for employees who work more than 20 hours per week for any employer, with some limited exceptions. Nationally, the Employment Retirement Income Security Act, commonly known as ERISA, preempts state actions to regulate employer self-insurance plans for employee health care coverage. ERISA was passed in 1974, months after Hawaii passed its Prepaid Health Care Act. As a result, Congress later exempted Hawaii's legislation as passed in 1974 from the terms of ERISA. An amendment to Prepaid Health Care adding substance abuse and mental health benefits was specifically excluded from the exemption. Congress thus expressed its intention to exempt only the Prepaid Health Care Act as passed in 1974, and not to allow substantive amendment of the measure.

We, therefore, believe that efforts to amend the Prepaid Health Care measure to deal with some of the affected groups is not a policy option at this time. Other means of covering the "gap group" have been explored.

These options include: an uncompensated care fund for hospitals similar to those in effect in New Jersey or Florida, expansion of Medicaid coverage for various groups (including pregnant women and children) as allowed under the OBRA (Omnibus Budget Reconciliation Act) amendments to the Social Security Act, state-subsidized gap group insurance programs such as those in Washington or Massachusetts, subsidy of unemployed worker insurance using the COBRA (Consolidated Omnibus Budget Reconciliation Act) obligation of employer insurance plans, direct service to the groups funded or provided by the Department of Health and insurance pools.

The Department has recommended after such study and application of these various policy options to Hawaii's health care environment that a combination of approaches be implemented. This combination entails:

1. A subsidized preventive basic health care insurance program to be offered to Hawaii's gap group.
2. An expansion of Medicaid to include pregnant women and children from 0 to 6 years of age in accordance with the provisions of the Federal OBRA provisions. This would enable eligibility up to at least 100% of poverty and the use of presumptive eligibility to allow coverage prior to eligibility certification only for pregnant women.
3. Flexibility to adopt other Medicaid options which might, in the future, be available and more cost-effective than the state health insurance plan.
4. Linkages with Prepaid Health Care, Medicaid and insurance providers to provide a thorough total state program to ensure that care needs are met.

THE STATE HEALTH INSURANCE PROGRAM

The Department's philosophy is that basic health care is a right of every individual in Hawaii. A right, however, that is also a responsibility which must be shared by each person in the total community. The State Health Insurance Program was proposed as a means of assisting individuals and families to meet their health care needs. Given current circumstances, the community cannot meet this need, and business has already greatly assisted through Hawaii's prepaid health care statute. This program is thus a partnership between individuals, families and government, a partnership in which costs are shared and in which the long-term health care future of Hawaii is greatly improved.

Several points must be made about the structure of this initiative as it is innovative and unlike any other program proposed by state government in the United States:

1. The program is preventive, the first of its kind nationally. It is based on the rationale that preventive health and primary care measures will significantly reduce catastrophic care costs. Much of today's health care insurance coverage is focussed on illness--mitigating the extensive costs of catastrophic illness while not funding the very preventive services which will reduce the possibility of catastrophic care. We believe that this trend must be reversed and have structured this program as a model in prevention.
2. The model we have developed is designed to be cost-effective, both for the present and for the future. First, it is extensively based on managed care by a health care provider. While restricting choice of the individual, managed care has been proven to be the most cost-effective means of care delivery. Second, the care to be covered will only entail a limited amount of inpatient care. With less inpatient coverage than "regular insurance", we do not

expect the plan to draw persons who are presently covered in other ways into the state subsidized program. Finally, the plan will be partly funded by the State, partly by the individual and family through a sliding fee schedule. Such a schedule, presently implemented in the State of Washington, will recognize the ability to pay of each participant and make each a partner with the State in this effort.

3. The importance in such an effort of outreach and health education cannot be overemphasized. While these do increase costs, they will ensure that the insurance program will truly reach those most in need. Such elements must be kept as integral elements of this effort.

The Department strongly believes that this program for the "gap group" is timely, cost effective, and will answer the major health care needs of that group--prevention and primary care. And, it is a bold step forward for America in cost-contained, managed, privately-provided primary care and preventive medicine for all citizens in one state. This plan, to be implemented in spring of 1990, differs significantly from a national health insurance concept, and fills the remaining health care gap by complementing the existing private medical care delivery and insurance system.

PLANNED FEATURES

The specific features of the plan we propose has the following elements:

1. Managed care. The plan does not plan to make use of the standard fee for service mechanism but will follow the more cost effective practice of having a selected provider or set of providers who provide the health care services for the insurance company. By providing the services in a package, an individual provider can more cost effectively deliver the services it is contracted to provide.
2. Preventive. The program is focused on prevention and primary care. Most outpatient modalities of services will be included. This will entail preventive services such as mammography, pap smears, immunizations, and routine physical examinations. By making preventive care available, the program will enhance prevention and early intervention of problems, thus reducing the long term need for the hospitalization an inpatient component entails.
3. The plan would provide very limited emergency room services. Presently for the gap group, care is episodic, based upon emergency or perceived emergency situations and delivered largely through hospital emergency rooms. Such care is often uncompensated, as

the recipient is unable to pay and the hospital is unable to collect. Yet, much emergency room use is based upon emergent minor problems, such as the case of the flu which can be dealt with either by a physician in his office or through patient education. By including patient education in the plan and by limiting emergency room visits to those related to trauma and other really emergency situations, we believe that the patient will both receive better care and the hospitals will reduce their uncompensated care costs, a persistent source of loss.

4. Maximal use of the Medicaid system is essential to strengthen care for the gap group. Utilization of cost effective Medicaid alternatives is thus a component of the system proposed. At this point, such utilization would entail fiscal support of Medicaid services for pregnant women and children from 0 to 6. As such, this coverage would provide the full range of Medicaid services, including EPSDT (Early and Periodic Screening, Diagnosis and Treatment), to children and pregnant women and children through 5 years of age. This would greatly reduce the gap group population in these age categories. An additional benefit of the OBRA coverage is presumptive eligibility, under which

pregnant women can receive services pending eligibility determination by Medicaid.

5. Outreach and health education are a vital importance in any such gap group effort. Many persons in the group are unfamiliar with the medical system, culturally reluctant often to access care because of shame and lack of knowledge of the availability of services. Good outreach is necessary to insure that the services are delivered. Health education is also necessary to insure that the services are properly utilized.
6. A sliding fee scale and co-payments are very important, as noted earlier. This insurance is designed as a partnership between the state and the family insured, with both sharing the cost. A sliding scale is contemplated, to ensure that even at the lowest end of the scale, a minimal partial payment is ensured.
7. The coverage will be contracted through insurance companies minimizing state bureaucracy. By doing so the private sector economics are maximally utilized for the benefit of the program.
8. The gap group insurance program is a crucial link between the prepaid health care population at the top of the scale and Medicaid population at the bottom. Filling the current gap between the two programs, the state health insurance program will utilize the current

systems in the Department of Labor and in the Department of Human Services. The Health Department, through these programs, hopes to touch people at both ends of the spectrum as they are falling into the gap, providing the necessary insurance to provide the needed health insurance coverage. Through this partnership which unites public agencies with the private sector and the individual at need, we hope to as fully as possible close the gap that currently exists in Hawaii. We see this coverage as a total systemic coverage which will ensure that the gap group is truly covered.

COVERED SERVICES

Generally, the services to be covered will be of preventive and primary care with some minimal inpatient coverage. The total package of services will be formulated with input from an advisory committee selected for the purpose. The package will likely include: standard medical visits, well child care, diagnostic radiology, diagnostic laboratory, pharmacy (at a sliding fee scale), medical consultation (through a gate keeper), health education, immunization and possibly other services such as outpatient surgery (for emergency and non-elective procedures).

The basic thrust of these services is to prevent and to diagnose early illnesses, then ensure quick and effective remedy.

We believe that overall a preventive package will demonstrate its effectiveness over a relatively short time frame (2-3 years). The program will result in lowered inpatient utilization and overall general lower costs.

The CHAIRMAN. Mr. Etheredge.

STATEMENT OF LYNN ETHEREDGE, INDEPENDENT HEALTH POLICY CONSULTANT, CHEVY CHASE, MD

Mr. ETHEREDGE. Mr. Chairman, this morning's testimony has described many of the increasing problems that small businesses have in obtaining insurance coverage. In my testimony, I want to cover two major questions about those problems:

First, why are they occurring; and second, will voluntary private market actions be able in the environment of the 1980s to assure affordable health insurance for small businesses?

Let's start with the question about why insurance companies are now using much more aggressive underwriting practices than previously, like exclusions of pre-existing conditions, substandard rating, denials of coverage in the small business market.

A major reason for this development is that the overall demand for private health insurance has been in steep decline in the 1980s. Most importantly, large employers have stopped paying premiums to insurance companies; they self-insure. Well over half of the employer market is now self-insured compared to only 5 percent in the mid-1970s. So the major insurance companies have lost that market.

Second, traditional insurance products are facing much stiffer competition from HMOs and PPOs, with enrollment growth from 9 million in 1980 to 47 million in 1988; and the number of uninsured has been growing by one million a year in the 1980s. So with these shrinking markets, private health insurance companies—for other reasons as well—are facing a financial beating. The 12 largest commercial insurers lost over $800 million in both 1987 and 1988. The Blue Cross and Blue Shield plans lost much more.

So health insurance companies are now competing much more aggressively because of their financial losses, because the markets are shrinking, and they are competing in what used to be a backwater, because that's where the market is now, the small employers' market.

Well, why, when they are competing are they not competing by cutting costs, the way some theorists used to say would happen? Why are they competing by underwriting practices, screening, and pricing people out of the market?

The major reason, Senator, is found in the chart which is at the end of my testimony. It is also critical to understanding the problems of voluntary solutions such as proposed by the Chamber and Senator Hatch.

This chart shows the incidence of health expenses across the population. It is not random the way some people think health expenses are, and it is not accidental, but it is highly concentrated. It shows, for example, that the 20 percent of the population with the highest health expenses accounts for 80 percent of our national spending each year, and the top 5 percent account for 50 percent. That 5 percent accounts for $250 billion per year.

Let me give you some rough cut-off numbers on there. The 80th percentile is roughly $8,000 per person. That's where the top 20 percent lie. The top 5 percent are people who cost over $20,000 a year for health care. So the insurer is trying to sell policies for $2,000 a year, obviously if they can, they will screen out the people who have the "big five", as Ms. Reed explained, the people who are in the highest categories who cost $8,000 a year or $20,000 a year.

Unfortunately for small employers, their groups don't average out these kinds of expenses, so it pays the insurance companies, when they try to get a much more profitable business base here, to use all of these underwriting tactics that we have heard described. That is where I disagree somewhat with other witnesses and with Ms. Reed. The problem, I think, is not with the small firms themselves or consumers. The problem is not with insurance companies. I think the problem is that everyone is acting rationally in this market the way it is structured, and that is why we need to fundamentally change the system in order to get better results.

Senator, the chart also illustrates why many of these voluntary solutions that well-intentioned people have proposed like multiple-employer trusts and high-risk pools, have not worked and cannot work in today's market.

Mr. Merlis has described some of these dynamics, but here is what would happen. If you and I went out and charged a $2,000 premium for people, what we would get into our pool is everyone whose expenses are over $2,000; anyone who can get insurance for less than $2,000 would not join our pool. We would get the people who have $8,000 or $20,000 expenses. And as soon as we raised our premium to cover those higher costs, some insurance agent would come in and say to some people in our pool, "I can get you that insurance for less." So those less expensive people would leave, we would be left with even more expensive people in our pool, and the pool would shrink and we would have this spiral. That is what has happened in all these multiple-employer trusts, the high-risk pools, and even in the Federal Employees' Health Benefits Program. And that is why multiple-employer trusts, for example, like COSE in Ohio, which has been cited often as a model for the Chamber and others—they are now being driven by the force of the competitive market to use practices such as age-rated premiums and substandard rating practices.

In today's health insurance system, where insurers compete by trying to sort out who is going to be healthy and who is going to be sick, and rate accordingly, these are the results that we can expect.

Those are the reasons, Mr. Chairman, why I think the competitive market is not solving the problems of small business; the private market is now making those problems worse. It is why voluntary solutions have not worked to date and why they will not work when health insurance companies compete on this basis.

That is why I believe small businesses need mandatory solutions and the restructured health benefits market that would be provided by the basic health benefits legislation.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Etheredge follows:]

PREPARED STATEMENT OF LYNN ETHEREDGE

Mr. Chairman and Members of the Committee:

I appreciate the invitation to testify before you today about health insurance coverage for small businesses.

My professional experience with these issues includes serving as OMB's lead analyst for health insurance issues under four administrations and directing its professional health staff from 1978 to 1982. Subsequently, I have worked with business organizations, insurance associations, provider groups, and legislative staffs to analyze alternatives for expanding public and private health insurance coverage.

Our nation's private health insurance system, Mr. Chairman, is now working more poorly each year. Insurance coverage is falling. Costs are rising. Risks and expenses, rather than being shared, are being shifted to the sick.

Into the late 1970's, optimists could hope that private insurance coverage would still grow and that competition among health insurers would slow health cost inflation. The 1980's have dealt harshly with wishful thinking. The number of persons without health insurance did not shrink; it grew from 25 million in the mid-1970's to 37 million today.[1] The real inflation of health costs did not subside; health costs have more than doubled from $248 billion in 1980 to $500 billion in 1987. During this decade alone, these increases have added $1,000 annually to America's per capita health bill.

Special Needs of Small Businesses

The small business market is now where the fissures in our health insurance system are most rapidly widening. The national problem of uninsured workers and their families is concentrated in this small business market. Forty-eight percent of uncovered workers are employed by businesses with fewer than 25 employees, and thirty-six percent work for businesses with fewer than ten employees. Administrative costs price the health insurance premiums for small businesses 25%-40% above the already high expense of health care. Driven by competitive pressures, community and group rating for small employers that once helped many of them to obtain affordable insurance is being replaced by such underwriting practices as exclusions of pre-existing conditions, large rate increases for firms with older workers or those in which a worker (or dependent) has the misfortune to contract a serious illness, segregating of workers with high risks from group rates, coverage denials (sometimes including exclusions of entire industries), and refusals to renew insurance.[2] State mandated benefits and premium taxes further inflate the health insurance costs of small businesses relative to large, self-insured firms, and tax advantages for small business owners are less generous. Thus, the failures of private health insurance to serve the small business market well are rightly a focus of this committee's concern.

The lessons of the 1980's show that two measures are necessary to deal with these problems. Both are embodied in the Basic Health Benefits for All Americans legislation.

o *Mandatory coverage*, with defined benefits and group rates, is the only fully satisfactory basis for assuring that these workers and their families can obtain affordable insurance protection; in the environment of the 1980's, voluntary solutions have not worked -- and will not work.

o A *restructured insurance market* is also essential to realize administrative savings for small businessmen and to focus market forces for achieving health care economies on their behalf.

Mandatory coverage

In reviewing evidence that leads to these conclusions, an appropriate place to start is by examining how competitive trends have been eroding the insurance market for small businesses.

Within the 1980s, the single most important insurance market trend has been that nearly all of the nation's large employers have abandoned traditional health insurance -- the premium-based purchasing of policies for group risk protection from an insurance company -- and now self-insure.[3] This shrinking market for purchased insurance, plus growing numbers of uninsured, has reduced the potential demand for private health insurers' policies. At the same time, enrollment in HMOs tripled from 9 million in 1980 to 29 million in 1988, and enrollment in PPOs grew from 1.3 million in 1984 to 17.5 million in 1987. In this environment, the nation's major health insurance companies have been battling rough seas. The twelve largest commercial health insurance companies reported underwriting losses of $898 million in 1987 and $830 million in 1988; [4] Blue Cross and Blue Shield plans lost even more money.

As a result of these trends, private health insurance companies are being driven to maximize profitability in what was once a backwater market for many of them, the small employer market. In doing so, insurance companies apply their expertise in risk selection and underwriting practices to avoid writing health insurance coverage for persons on whom they are likely to lose money. Large groups are not usually subject to such practices. But small businesses individually do not have the market clout to bargain with insurance companies, and they are not large enough for their employment group to average out healthy workers with higher expense workers, e.g. an older employee with coronary artery disease or a dependent child in need of a liver transplant. It pays insurance companies to pick and choose their risks when they can, and to rate accordingly, and they are now aggressively doing so in the small business health insurance market.

The attached chart (Chart 1, end of testimony) illustrates the circumstances that now underlie the health insurance industry's underwriting practices. The chart shows that the distribution of health care expenses among individuals. Approximately 5% of the U.S. population account for about 50% of national health expenditures each year, and the top 1% for about 20%. A similar distribution, although not as steep, also holds true when the health expense premiums of small firms are compared. Who is in an insurance company's risk pool compared to the premium charged -- particularly how many of the high expense population -- is *far* more important to an insurer's profitability than are the cost savings it might be able to achieve by seeking health care economies.

Many of these expense differences are predictable by insurance companies from their data bases, employee application forms, medical advice, a firm's and employee's previous health expenses and actuarial analyses. Thus, the armaments of pre-existing condition exclusions, denials of coverage, sharp rate increases and other practices detailed by witnesses this morning.

Many insurers do not like the social consequences of using these underwriting practices in the small business market. But, in an increasingly competitive and profit-oriented market, health insurance companies *must* engage in such practices -- because their competitors do. If an insurance company allows its competitors to skim off workers and firms who are good risks, it will be left with the "demographic sludge" and a greater probability of losing money or being priced out of the market. In the 1980's, the natural result of unstructured health insurance competition in the small business market is not health care economies, as some theorists had hoped, but greater reliance on underwriting practices and risk-pool selection.

The extent to which underwriting practices now vitiate the spreading of risk -- which is the primary social value of health insurance -- was illustrated recently by the president of a large health insurance company. In order to match his competitor's pricing, he reported that his company now prices the same basic insurance package from $25/month to $165/month within a single state, depending on an individual's age, sex, area of residence and other factors. Based on the increasing competition to skim off better risks, the least expensive premium will soon be lowered to $15/month, requiring an increase to $200/month for the most expensive rating category.

These underwriting and selection dynamics are the forces which drive onto the rocks the voluntary pooling solutions which well-intentioned people have advocated as solutions for small businesses. Whether such pools are formed by community-rating for small groups, multiple employer trusts, or high risk pools, all suffer from the fact that high expense firms and individuals join such pools and competitive insurers skim off the better risks. Both events force up premiums for those in the pool to the point that it becomes uneconomic for many persons whom it was supposed to help. Even multiple-employer arrangements such as the Council of Smaller Employers (COSE) in Ohio -- once cited as a model for small businesses -- have now had to adopt health insurance company practices such as medical underwriting for companies with fewer than 10 employees and to make use of age rating and substandard rating practices that sharply raise rates for employers with elderly workers or above-average utilizers.[5]

In sum, the increasingly competitive market for small business insurance in the 1980's -- because of the underwriting and selection practices insurance companies must now use to compete with each other -- has not and will not assure that health insurance is available for all workers and their families at affordable rates. Mandatory coverage, including basic benefits and group rating requirements, such as those included in the Basic Health Benefits for All Americans legislation, are essential.

A Restructured Insurance Market

A major consequence of the unstructured competition in today's small business health insurance market is unnecessarily high administrative costs and inefficiencies. Many factors contribute to these expenses, such as sales commissions, employee turnover, and the volatile market between employers and insurers, leading to risk premiums and practices such as durational rating. Such factors add 25% to 40% to the health insurance premiums of small businesses. A well-conceived administrative structure for the small business market, including common basic benefits and community rating, could reduce these expenses. Similarly, by targeting competition among insurers, HMOs and PPOs toward making available more economical care -- rather than on underwriting practices -- employers can achieve further savings. Indeed, such a design has long been advocated by leading theorists as the best way to structure a health care market. Estimates for such savings are in the range of 10% to 25%. In these respects, the Basic Health Benefits legislation would also make notable progress for small businesses, their employees and families in obtaining more economical health care.

The Benefits and the Costs

The primary beneficiaries of this legislation will be the 23 million uninsured persons in families with a least one member who works full time. One-third of the uninsured are children. Nevertheless, analyses by the Congressional Budget Office and Actuarial Research Corporation show many other identifiable groups in our society also stand to benefit.

o Large corporations should gain from reduced cost-shifting by hospitals, physicians and other providers that can result in markups of 30% and more on employers' bills to cover the costs of the uninsured. With expanded health insurance coverage, hospitals and others ought to see that such savings are passed on.

Federal requirements could be added to assure that these price reductions are realized. Such legislation, tied to non-profit status, would limit the markups to cost that hospitals will be permitted after the Basic Health Benefits law is enacted and tax away income that exceeds such standards.

o Most small businesses will also realize savings, since they also already offer health insurance to their employees. In fact, 60% of businesses with 25 or fewer employees now offer coverage, as do nearly three-quarters of firms under 100 employees. Such economies will result from lower administrative costs and the same reduced cost-shifting as for larger employers. As well, these businesses may save from the exemption from state mandated benefit laws, and from economical insurance coverage by the competing regional carriers.

o Insurers will reap benefits from approximately $18 billion of new underwriting business. This new business comes at a time when private health insurance coverage is in decline and most large insurers are awash in red ink. Legislation such as Basic Health Benefits offers an unparalleled economic opportunity for health insurance companies. It features fair, structured competition -- and more than enough new premium revenues for many insurance companies to prosper.

o Hospitals, physicians and other health care providers will gain a broader business base and a more secure financial future.

The major threats to their survival -- increasing numbers of uninsured and price-cutting by providers who do not shoulder a fair share of the uninsured population's care -- will be largely eliminated. Health care providers will be able to spend more time on meeting the medical needs of their patients and can reduce their concerns about deteriorating financial condition, advertising for paying patients, and bill-collecting.

o Most Americans will benefit from the assurance that their children, relatives, friends --and themselves -- will be able to choose employment based on what they want to do with a guarantee of basic health insurance protection. As employees of large firms or small businesses that now offer health insurance protection, many may also gain from less cost-shifting of expenses for the uninsured onto their health insurance premiums.

There are major expenses that will result from this legislation. They will fall primarily on the minority of businesses, especially small businesses, that do not now offer health insurance to their employees. Such expenses will only grow larger, however, if we allow private health insurance gaps to widen still further and those costs will be spread even more inequitably, e.g. through cost-shifting.

Asking all businesses to bear these costs is the right way to even the playing field in a competitive marketplace and to end "free-riding" and cost-shifting that is unfair to the great majority of Americans and employers. This approach also helps to preserve new government funds -- which are in short supply -- for assisting lower income persons and other purposes where such funding will truly be needed. Finally, small businesses with costs more than 5% of gross revenues will be eligible for government assistance for 75% of the excess costs, and alternative standards are also provided for in the bill. The burdens will thus be modest, in percentage terms, for nearly all employers, and, as shown in several studies, are unlikely to result in significant adverse economic consequences.

Conclusion

In conclusion, the health insurance market of the 1980's has laid to rest any hope that voluntary actions will lower the numbers of 37 million uninsured, now steadily increasing. Failure to act will predictably see insurance coverage continue to fall, health costs continue to rise, and small businesses increasingly subjected to socially undesirable insurance underwriting. The Basic Health Benefits proposal will be of broad benefit to our society, and it embodies principles required to solve these problems for small businesses, their employees and families.

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[1] The number of uninsured is now greater than the combined populations of: Maine, New Hampshire, Vermont, Connecticut, Rhode Island, Delaware, District of Columbia, West Virginia, Arkansas, Mississippi, Iowa, North Dakota, South Dakota, Kansas, Nebraska, New Mexico, Idaho, Wyoming, Montana, Utah, Nevada, Oregon, Alaska and Hawaii.

[2] A recent discussion of these practices is Insuring the Uninsured: Options and Analysis Congressional Research Service, October 1988 pp 29-40.

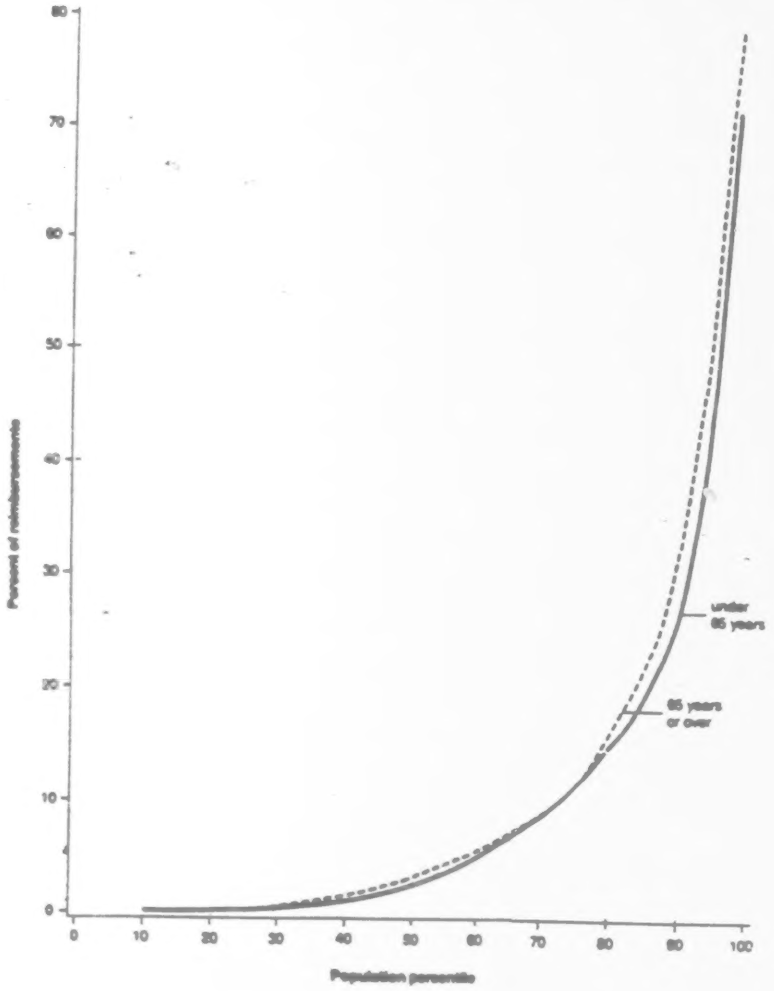
[3] Self-insurance grew from 5% of employer group health benefits in 1976 to 30% in 1980 and 55% in 1985 (HIAA).

[4] Medical Benefits May 30, 1989 pg 2

[5] CRS op. cit. pg 39

Chart 1

Cumulative percent of charges attributable to various percentiles of United States residents, by age: 1980



NOTE: Data on the noninstitutionalized population only is included in this figure
SOURCE: Garfinkel, Riley, and Iannacchione, 1988.

The CHAIRMAN. Mr. Sandmeyer.

STATEMENT OF RONALD P. SANDMEYER SR., CHAIRMAN AND PRESIDENT, SANDMEYER STEEL COMPANY, PHILADELPHIA, PA, ON BEHALF OF NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. SANDMEYER. Thank you, Mr. Chairman, for this opportunity to present our testimony.

I am Ronald Sandmeyer, President of the Sandmeyer Steel Company in Philadelphia, Pennsylvania. My company, now 37 years old, manufactures stainless steel plate and plate products for the capital good industry, and we employ 165 happy people.

Today I am appearing on behalf of the 9,000 small manufacturers affiliated with the National Association of Manufacturers, and I wish to thank you, Mr. Chairman, for holding this hearing on S. 768, on access to health care for the uninsured.

While a small company, we do self-insure for health insurance and have implemented a range of cost management strategies, but to no avail. Last year alone, our costs for health care went up 41 percent. Our average annual increase over the last five years is 20 percent—far above any other costs we incur.

I want to commend Senator Hatch for his leadership today in introducing a comprehensive legislation program that strives to reduce cost, share responsibility, and level the playing field. The NAM is very concerned about the estimated 37 million people without health insurance. We believe that access should be extended to the uninsured on a phased basis, with first priority given to children. Phased expansion is necessary to permit parallel improvements in both quality and efficiency and to assure that services are appropriately targeted to those most in need.

We support the underlying principles of the comprehensive and uniform remedy for the Health Care System Act of 1989 because it builds on the success of the voluntary, employer-supported system of health benefits and existing Federal programs.

In the area of quality, the legislation would expand medical effectiveness research and authorize the Assistant Secretary for Health to set up treatment practice guidelines which could be used as a defense in litigation. High medical liability and defensive medicine costs require aggressive action, and we strongly support this provision.

The bill would reduce barriers to obtaining health insurance by preempting State-mandated benefit laws and establishing State pools for the uninsured. We support this provision.

In the prevention area, the encouragement of workplace programs and public service announcements and better coordination of prenatal care are all important proposals that would contribute to a more effective health care system.

We understand this legislation would cost an estimated $313 million. While identifying new dollars or reallocating existing resources is a big challenge, we should not overlook the potential for cost savings, for example, in prenatal care or what is not spent on inappropriate procedures or diagnostic tests.

Senator Hatch's proposal is an important first step in system reform. Much more remains to be done. We urge the Senator to support future legislation to expand Medicaid to cover more of the poor uninsured. Additionally, we urge this committee to pursue development of Federal medical liability legislation to help control the high cost of health care.

As I have indicated, the NAM supports Senator Hatch's legislation as a means to address access to as well as the cost and quality of health care.

This approach is preferable to mandates as proposed by S. 768, which we believe would lead to increased health costs, diminish American competitive strength in a worldwide economy and jeopardize jobs.

We would be pleased to respond to the committee's questions, and we thank you for this opportunity to present our views this morning.

I would ask that the full text of my written testimony be included for the record and that NAM's white paper, "Meeting the Health Care Crisis", also be included.

Thank you very much.

[The prepared statement of Mr. Sandmeyer (with an attached publication) follows:]

Testimony of Ronald Sandmeyer, Sr.
Chairman, President, and CEO
Sandmeyer Steel Company

on behalf of the
National Association of Manufacturers
on "The Comprehensive and Uniform Remedy
for the Health Care System Act of 1989"
before the Labor and Human Resources Committee
U.S. Senate
June 23, 1989

Mr. Chairman and members of the Senate Labor and Human Resources Committee, I am Ronald Sandmeyer, President of the Sandmeyer Steel Company, Philadelphia, PA. My company, which manufactures stainless steel plate and plate products, employs 165 people. Today, I am appearing on behalf of the National Association of Manufacturers. I am accompanied by Sharon Canner, NAM's Assistant Vice President, Industrial Relations. I wish to thank you Mr. Chairman, for holding this hearing on S. 768 and access to health care for the uninsured.

Senator Hatch, as the ranking minority member of this committee, we want to commend you for your leadership in developing comprehensive legislation that addresses access to, as well as the cost and quality of health care. While I am today representing a small firm in this hearing, I am also speaking for large companies as well which are equally as concerned about these issues.

This testimony will comment on both proposals regarding access, with greater attention to Senator Hatch's bill, since NAM has provided extensive testimony on S. 1269 (Kennedy D-MA) in the 100th Congress, a bill similar to S. 768.

HEALTH CARE ACCESS, COST AND QUALITY

The Uninsured

The March 1987 Current Population Survey (CPS) conducted by the U.S. Census Bureau reported that in 1986, 83 percent of Americans under age 65 were covered by health insurance. Three-quarters obtained coverage either through their own employment or that of a family member. The rest were covered through a mix of Medicaid, Medicare, Champus, private insurance or other sources.

Yet, an estimated 37 million or 17 percent had no coverage. This percentage was the same reported in 1984 and 1985, but substantially greater than that reported in the early 1980s. Of the uninsured, nearly one-half were workers and another one-third were children under age 18. Only 18 percent of the uninsured were nonworking adults. Uncovered workers tend to work at lower-paying jobs, some are self-employed, employed in retail trade or services, employed part-time or intermittently or work for small firms that do not provide health benefits. A small percentage are medically uninsurable.

Coverage for manufacturing firms is high. A January 1989 survey of NAM members revealed that of companies with fewer than 25 employees, 96 percent offered benefits to workers and 94 percent offered such benefits to dependents as well. For larger companies the coverage rates neared 99 percent. While some self-selection in the survey may have occurred, other studies, such as that conducted by the U.S. Small Business Administration, tend to confirm these numbers.

Medicaid, enacted in 1966 to provide health insurance for the poor, today covers only approximately 40 percent of those at the federal poverty line, largely as a consequence of differences in state eligibility criteria. Added to this problem is the declining percentage of Medicaid dollars actually going to low-income persons. Currently, benefits for the disabled and elderly long term care services use 60-65 percent of the Medicaid budget.

Cost and Quality

National health care expenditures rose by 8.5 percent in 1986 and 9.8 percent in 1987 which represented over 11.5 percent of the Gross National Product (GNP). Health benefits, according to the Employee Benefits Research Institute (EBRI), have become a major part of labor costs. By comparison, the other 23 Organization for Economic Cooperation and Development (OECD) countries spend an average 7.2 percent of their economy on health care, a fact which places the United States at a competitive disadvantage in world markets.

From 2.4 percent of total compensation and 23 percent of total benefits in 1970, health costs grew to 5.4 percent of total compensation and 33 percent of all benefits in 1987. A January 1989 survey of NAM members showed that the cost of providing benefits had risen 29 percent over the previous year. This increase was on average equal to 37 percent of net profits. Parallel quality or service gains have not emerged to justify these cost increases.

The underlying causes of inefficiency in the U.S. health care system are numerous, including a payment system that encourages uneconomical buying decisions; duplicate capital investments; uneven quality and appropriateness of care; a bias towards excessive and sometimes inappropriate use of technologies, and a malpractice liability environment that significantly escalates health care costs.

The problems of access to health insurance, and the cost and quality of care are interrelated issues that must be addressed in an integrated fashion. Expanded access should be phased in to assure that increased participation in the health delivery system not lead to greater health cost inflation and that services be allocated to the most needy. Failure to address these difficult choices now will eventually lead to future rationing of health care.

The interrelated problems of access to, cost and quality of health care will require system-wide improvements. The Comprehensive and Uniform Remedy (CUR) for the Health Care System Act of 1989 (Hatch R-UT) takes some important first steps in that direction. Of course, much more remains to be done by both the private and public sectors.

Attached is a brief list of these areas for attention, which is drawn from "Meeting the Health Care Crisis", a recent NAM study of the problems of the U.S. health care system.

"BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT" (S. 768)

S. 768, introduced by Senator Kennedy (D-MA) in April, requires all employers to provide health insurance to employees (working 17-1/2 hours/week or more) and their dependents. The bill defines a specified package of benefits, limits employer/employee costs and out-of-pocket spending, and establishes subsidies for small business. A Medicaid-like program would serve all persons below the federal poverty line by the year 2000.

Senator Kennedy, we commend you for raising the issue of the uninsured. Your efforts have sparked much discussion over the problem of access and have led to the development of a number of proposals to expand coverage.

NAM, however, opposes the mandating of employer-provided health benefits as a means to improve access for the uninsured. Increased health care utilization resulting from this mandate would exacerbate already high health care inflation rates. Raising manufacturing costs by mandating benefits would diminish American competitive strength in the global marketplace and could ultimately jeopardize the job and job potential of these we are trying to help. Small manufacturers known for their ability to innovate would be especially impacted by mandates. We believe in giving employers the flexibility to design benefit programs that specifically meet the needs of their employees. Flexibility means offering choices to employees as well.

While we support extended coverage, we strongly believe this must be based on a thorough understanding of the composition of the estimated 37 million uninsured. Expansion must be phased to make cost effectiveness and coverage gains that strive for greater efficiencies in the delivery of health care.

THE PROPOSED "COMPREHENSIVE AND UNIFORM REMEDY (CUR) FOR THE HEALTH CARE SYSTEM ACT OF 1989"

Senator Hatch, we applaud your concern with and attention to the overall problems of our health care system. We are in agreement with the underlying principles of your proposal to reduce health care costs, share responsibility, and level the playing field in order to expand access to health care coverage. We are supportive of the bill's efforts to improve prenatal care; remove barriers to facilitate less expensive health insurance; enhance medical effectiveness research to improve quality and address medical liability costs; and encourage workplace prevention programs.

We note however, while Medicaid is briefly referenced in the findings of the legislation, it is not directly addressed in legislative language. A key element in improved access to care is an expanded Medicaid program that would cover more of the poor uninsured. This should be done on a phased basis with first priority given to children. The expanded program should include a "buy-in" arrangement to permit certain low-income workers who cannot qualify for Medicaid an opportunity to buy Medicaid benefits with the premium share tied to income.

Additionally, we urge the committee to pursue development of federal medical liability legislation. The high cost of litigation and defensive medicine not only raises health costs, but leads to inappropriate and sometimes poor medical care.

Improving Prenatal Care

This bill would place greater emphasis on federal prenatal care services by coordinating existing prenatal programs which are currently scattered in at least five separate programs.

It is estimated that for every $1 invested in prenatal care $3 in neonatal care is saved in the child's first year and $11 is saved over the child's lifetime in medical, social and education costs. Particularly, since the United States ranks well behind the other major industrialized countries in infant mortality, it is important to increase efforts in this area.

Removing Barriers to Affordable Health Insurance

Senator Hatch's legislation proposes to preempt health benefit plans from state insurance laws which currently dictate the content of health insurance purchased in the state. Generally, small firms which do not self-insure find it difficult to purchase low-cost basic health insurance since most standard policies usually include required services and/or providers such as alcohol and drug abuse coverage, and nutrition counseling, for example. While such services and particular health care providers, are in of themselves appropriate under certain circumstances, mandates deter employers and employees from determining the best mix of benefits suited to individual company and worker needs.

Such mandates add significantly to the cost of health insurance. For example, a recent study by Peat Marwick Main & Co. for the state of Hawaii, estimated that mandating chiropractic services would cost $8.1 billion. Yet, there was no evidence to indicate that lack of such servies resulted in financial hardship for people using the services. We support the preemption of state mandated benefit laws that make it difficult for employers to purchase basic low-cost health coverage.

State uninsurable pools would be established with incentive block grant funds ($50 million) available as seed money. For states that did not establish a pool, the Secretary of the Department of Health and Human Services (DHHS) would be authorized to develop the pool. Underwriting of any losses would be funded from general revenues appropriated by the state. The legislation defines "uninsurable" as a person rejected by one or more insurers and who is not eligible for Medicaid or Medicare.

While only 15 states have actually implemented such pools, there is some evidence to indicate that this approach has some merit in making insurance available for people who, because of an insurable medical condition, cannot obtain insurance even if they are employed by a company that offers insurance. Such state pools could have the effect of making coverage for small firms more affordable since the very "high-risk" persons would be placed in a state pool. In this regard, it is important to adhere to the very narrow definition of "uninsurable" and to otherwise encourage employers to continue sponsoring plans for their other employees. To help control utilization and restrain cost increases, the state pool should include options for managed care, various cost containment techniques, and reasonable levels of cost-sharing.

Health Care Quality Improvement and Medical Liability Reform

Senator Hatch's legislation would (1) increase the authorization for patient outcomes research to $100 million per year; (2) authorize the Assistant Secretary for Health of the Department of Health and Human Services (DHHS) to establish treatment practice guidelines to be used as a defense in medical malpractice litigation; and (3) utilize the guidelines as a basis for denial of reimbursement under Medicare.

Research has demonstrated that some medical care is of questionable value, inappropriate, not needed such as unnecessary surgery for hysterectomies and coronary-bypasses, and that certain treatment is actually harmful. The Rand Corporation estimates that cutting the use of inappropriate procedures could save 10 percent of the U.S. health care budget or $50 billion a year.

A number of related activities are underway: DHHS has budgeted $52 million in fiscal year 1990 on effectiveness research, several House and Senate bills to expand research have been introduced, the American Medical Association is developing appropriateness guidelines for physicians, and some private insurers are beginning to base reimbursement on adherence to certain guidelines for diagnostic tests. These efforts would be further strengthened by the proposed legislation. Tying guidelines to reimbursement for Medicare would have a spillover effect to the private sector just as Medicare's DRG system became a standard for much private-paying hospital reimbursement.

The use of guidelines as a defense in litigation could potentially help curb the costs of medical liability. It is estimated that malpractice premiums are about 1 percent of health costs or $5 billion a year and costs of defensive medicine are approximately $20 billion a year. It is unclear what the legal challenges may be to this approach, but it is important to begin seriously pursuing this option to attack high medical malpractice costs.

In addition to the provisions noted above, we urge that this committee pursue broad medical liability legislation at the federal level. Such legislation should place limits on contingency fees and punitive damages, strengthen standards for negligence, and establish no-fault compensation for certain areas of liability, as was recently done for vaccine-related injuries.

Prevention and Health Care Costs

For work-based prevention programs, the Hatch proposal would clarify the existing tax treatment of these efforts. Currently such efforts receive favorable tax treatment, but the immediate payoffs are not always apparent to employers and insurers, and thus these efforts are not given enough attention as a part of the health benefit plan. Highlighting the tax preferences for workplace prevention programs would be a means to encourage these activities with their potential to affect health care costs.

The DHHS would sponsor public service announcements explaining how to obtain health benefits, use these benefits more effectively, make better use of the health care system, and take greater responsibility for one's own health. Lifestyle changes such as smoking cessation, weight control, and exercise can go a long way toward stemming the rise in health care inflation. This consumer education effort is also important since both the federal government and the private sector continue to make benefit design changes as a means to improve efficiency. Consumers need to understand such changes in cost-sharing, system delivery, and reimbursement and how they can cooperate in these efforts.

Improving the Trauma Care System

The proposal would (1) establish a clearinghouse on Emergency Medical Services and trauma care and fund demonstration programs; and (2) establish a state block grant program to prevent accidents, improve Emergency Medical Services systems and pay for uncompensated accident care.

It is estimated hospitals provided $7 billion in unsponsored or uncompensated care in 1987. These costs resulted from bad debts, unpaid bills of patients and other factors. Some hospitals, often those in the inner city, provide a disproportionate share of this care. To some degree, hospitals shift the cost of unsponsored care to private-paying patients thus pushing up employer costs.

The prevention of accidents and improving trauma care has the potential to save money in the long run. Whether the proposed level of funding is appropriate and a clearinghouse is needed are issues upon which we do not feel qualified to comment here. Generally, we feel that hospitals should have sufficient resources to deal with the mix and intensity of community trauma needs. At the same time, it is essential that receipt of federal funds authorized under this legislation be conditioned on adherence to cetain efficiency and cost-effectiveness standards.

CONCLUSION

Senator Hatch's legislation is an important first step in addressing the complex and interrelated problems of access to, cost and quality of health care. Proposals to improve prenatal care, remove barriers to facilitate less expensive health insurance, enhance medical effectiveness research to improve quality and address medical liability reform, and encourage workplace prevention programs deserve thoughtful consideration.

CUR would cost an estimated $273.5 million. While identifying new funding or re-allocating existing resources to fund this legislation is a big challenge, we should not overlook the potential for cost savings, for example, in prenatal care and in what is not spent on inappropriate procedures and diagnostic tests, as well as the cost of continuing to do nothing.

To adequately address the broader access problems of the system, it is essential that Medicaid be expanded on a phased basis to cover more of the poor uninsured. This element, not addressed by this legislation, would serve to roundout the system approach to reform and discourage the cost-shifting and inequities in our current system. The committee should support such legislation. Additionally, we urge the committee to develop federal medical liability legislation. The NAM is pleased to work with you in these endeavors and other efforts to improve our health care system.

"MEETING THE HEALTH CARE CRISIS"
10-POINT PROGRAM TOWARD A HEALTHIER U.S. HEALTH SYSTEM
NATIONAL ASSOCIATION OF MANUFACTURERS
May 23, 1989

The following is an outline of first steps toward a more competitive cost management strategy for the U.S. health care system:

- All purchasers and providers of health care should cooperate to achieve a cost-management system that defines the health care product and judges its quality. Elements of such a program should include sound public information on providers, incentives to encourage employer-based coverage and improved management of public programs. A major effort should be made to develop a process to provide continual information on health care quality and appropriate treatment.

- Data on individual hospitals and physicians should be publicly available to assist purchasers in making intelligent buying decisions. All states should enact such laws, and compliance should be a condition of receiving federal Medicaid funding.

- Employees should be educated consumers of health care. Individual responsibility for one's own health should be stressed. Employees should be instructed on how to use the health care system and health benefits better, and greater emphasis should be placed on preventive health care. Where appropriate, labor unions should strive to support these education efforts.

- Medical liability reform should be pursued at the national level with limits placed on contingency fees and punitive damages. We should strengthen standards for negligence and establish no-fault compensation for certain areas of liability.

- Medicare should continue to refine the Diagnostic Review Groups (DRGs), a payment system for hospitals--to smooth out irregularities and update payment rates. New methods should be developed to replace the current prevailing fee environment for paying doctors.

- The federal government should use its purchasing power under Medicaid and Medicare to encourage a more efficient marketplace. Public programs should stress the use of managed care to hold down costs and improve efficiency.

- We should encourage insurance arrangements, such as multi-employer trusts (METs), that enable groups of firms and workers to join together to obtain more favorable underwriting terms. Similarly, basic catastrophic plans that exempt state benefit mandates should be made available to make coverage more affordable to small firms.

- Employers should be provided with tax incentives to voluntarily prefund health benefits for their retirees. Proposed Financial Accounting Standards Board (FASB) rules for retiree health obligations serve to highlight the immense growth in future employer health care spending--spending that will restrict the availability of health care for all employees. These standards underscore a need for employer tax incentives.

- Section 89 nondiscrimination rules of the tax code should be repealed. The law requires employers to meet unrealistic standards to prove nondiscrimination. These rules create costly administrative burdens that discourage employers from expanding health benefits coverage and may lead to termination of insurance altogether, particularly for some small businesses.
- Employers must make a greater effort to control the costs of their health care programs, focusing on employee education, quality and appropriate care, and adopting health plans that yield the best health outcomes and make judicious use of deductibles and cost-sharing.

The **Chairman**. Thank you.

Mr. Naylor.

Mr. **Naylor**. Mr. Chairman, I will summarize my remarks but ask that the full text of my testimony be printed in the record.

The **Chairman**. It will be included in its entirety.

STATEMENT OF W.W. "BIFF" NAYLOR, PRESIDENT, AMERICAN RESTAURANT SERVICES, INC., LOS ANGELES, CA, ON BEHALF OF NATIONAL RESTAURANT ASSOCIATION

Mr. **Naylor**. Mr. Chairman, members of the committee, I am Biff Naylor, President of American Restaurant Services. I serve on the Board of Directors of the National Restaurant Association and appear today on their behalf.

With over 626,000 establishments, 70 percent of which have sales of $500,000 a year or less, the food service industry employs over 8 million workers. In addition, I am a managing general agent and founding member of the American Restaurant Employers Trust.

In July 1975, a group of restaurant employers got together to provide a quality health insurance plan for restaurateurs in Southern California. Our experience was so positive that we opened up our program to other States in 1986. Since that time, the program has grown to include nine States, and 377 employers have joined the plan, covering 6,700 employees.

I want to thank you for this opportunity to participate in the debate on what we consider one of the most serious problems facing our Nation. All of us in the room want to develop a solution to this complex problem. The ways we choose to solve it may vastly differ.

Mr. Chairman, the National Restaurant Association commends your dedication to improving the Nation's health care delivery system, and for your efforts in responding to some of the problems raised by the business community.

For those of us who operate in the real world of running a business, the mandate approach contained in S. 768 cannot be modified to make it acceptable. Therefore, Mr. Chairman, we must oppose your bill and continue working in support of incentive-based solutions like the one proposed by Senator Hatch.

We view the Hatch bill as a significant first step in a series of measures that will improve access to health care in this country.

Mr. Chairman, restaurants and other industries dominated by small businesses would bear the heaviest burden if S. 768 were enacted. The very characteristics that have made them such a dynamic economic force and the source of millions of entry-level jobs also make them especially sensitive to labor cost increases.

The Congressional Budget Office report on your bill determined that businesses might decide either to pass on the higher benefit costs to consumers or absorb the costs by lowering their profit margins. For restaurants, these are not alternatives.

If I may, I would like to give you an example of how out-of-line this legislation is with restaurant business practices.

Under S. 768, if the cost of compliance for a small employer exceeded 5 percent of gross revenues, the Federal Government would subsidize the excess. The 1987 Restaurant Association survey indicates that in 1986, full menu table service restaurants on average had a before-tax income of only 2.4 percent. It doesn't take a mathematical genius to figure out that an increase of labor costs equal to 5 percent of sales would sentence these employers to bankruptcy and their employees to joblessness.

We conducted a survey of our members in early 1988 to determine the availability of employer-provided health benefits and their characteristics. The results of our industry survey were very much in line with those of the rest of the business community: The larger businesses provide benefits, the smaller ones do not.

Mr. Chairman, after analyzing your mandated health insurance proposal, it became clear to us that you are attempting to legislate a massive new program without critical information about the needs of workers in our industry. The restaurant business has a unique work force—young, transient, working a second job, going to school—and they are not necessarily in need of the same benefits as, say, auto workers.

For this reason, our Board has established a task force that is in the process of designing further research on this subject. We are going to survey our employers again about their experience in providing health insurance for employees. And we are going to survey a cross-section of restaurant workers about their unique benefit needs. To the best of our knowledge, there is very little information available on employee needs in our industry or any other industry. We believe more information will help us help you design a workable system combining private sector initiatives and cost-effective government-sponsored programs to benefit the unemployed and the poor. We look forward to sharing our data with you and the staff at a later date.

One thing we do know is that most companies that do not provide health care cannot afford to do so. And if a company cannot afford health insurance today, a mandate from Washington will not make it affordable tomorrow. We also know that most employers that currently provide insurance are experiencing dramatic cost increases.

Senator Hatch has introduced legislation today and has announced his intention of introducing more in the future which will seek to address these cost problems. We whole-heartedly support his efforts in this area and ask the committee to help him carry them out.

The areas where change must be made are: preemption of State mandates; assist States in setting up State-run pools for the uninsurable; give all businesses a 100 percent deduction for health insurance; provide a tax credit for employers who have no taxable income and yet provide health insurance for their employees; and malpractice reform.

In my capacity as a trustee of American Restaurant Employers' Trust, I regularly discuss health policy issues with restaurant owners throughout the country. I feel confident in saying that most of them who do not offer health insurance for their employees would like to do so, but don't know enough about the options available to them. The Trust provides benefits that are not as generous as those you propose. They are, however, tailored to meet the needs of our industry—the employers and the employees. Employers and employees share the burden and find it acceptable. We have just scratched the surface but are certain we can dramatically expand coverage to more people. Senator Hatch's proposal would give us that chance.

Mr. Chairman, I thank you again for this opportunity to present the views of the National Restaurant Association. We would like to continue working with the committee to develop an incentive-based incremental plan to solve this crisis. No one wants to duck this very serious problem of health, but a mandated approach is simply not the only answer and will only end up huring those we are trying to help.

Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Naylor follows:]

PREPARED STATEMENT OF W.W. "BIFF" NAYLOR

Mr. Chairman, members of the Senate Committee on Labor and Human Resources, I am Biff Naylor, President of American Restaurant Services, Inc. We own and operate the Cafe River City in Sacramento, Tiny's Family Restaurant in Capitola and seven Cindy's Coffee Shops in northern California.

I also serve on the Board of Directors of the National Restaurant Association, and appear today on their behalf. This organization is the leading trade association for the U. S. foodservice industry, representing tableservice restaurants, fast food outlets and cafeterias, and institutional feeders such as hospitals, universities and military clubs. With over 626,000 establishments, 70 percent of which have sales of $500,000 or less, the foodservice industry employs eight million workers. In 1989, the industry will contribute $227.3 billion to the Gross National Product.

In addition, I am a managing general agent and founding member of the American Restaurant Employers Trust (ARET). In July, 1975, a group of restaurant employers got together to provide a quality health insurance plan for restaurateurs in Southern California. We thought we could successfully manage an insurance trust that was specifically designed to meet the needs of restaurant employers and employees. Our experience in Southern California was so positive that we opened up our program to other states in 1986. Since that time, the program has grown to include nine states (California, Arizona, Georgia, Maryland, Missouri, Mississippi, North Carolina, Tennessee and Virginia). As of the end of the first quarter of 1989, 377 employers have joined the plan--covering 6,700 employees at an annualized premium in excess of $9 million. It is the intent of the trustees to make this program available in all 50 states and to become the premier group health insurance program in the foodservice industry.

I want to thank you for this opportunity to participate in the debate on an issue that we consider one of the most serious problems facing our nation--that millions of Americans lack access to adequate health care. All of us in the room want to develop a solution to this complex problem--but the ways we choose to solve it may vastly differ.

NATIONAL RESTAURANT ASSOCIATION POSITION

Mr. Chairman, the National Restaurant Association commends your dedication to improving the nation's health care delivery system, and for the efforts you have made thus far in responding to some of the problems raised by the business community during the 100th Congress. But for those of us who operate in the real world of running a business, the mandated approach contained in S. 768 can not be modified to make it acceptable. Therefore, Mr. Chairman, we must oppose your bill and continue working in support of incentive-based solutions like the one proposed by Senator Hatch. We view the Hatch bill as a significant first step in a series of measures that will not only improve access to health care in this country, but will also reduce health costs, distribute the responsibility more equitably between the public and private sector, and make it possible for all employers who wish to provide health insurance for their employees able to do so. Because this situation is so complex and we are at the same time facing serious fiscal constraints, we feel that we must chip away at this problem in increments.

IMPACT ON RESTAURANTS

Mr. Chairman, restaurants and other industries dominated by small businesses would bear the heaviest burden if S. 768 were enacted. With lower profits, less stability and greater employee turnover than their larger counterparts, small businesses would be least able to offer the benefit package required under the bill. And their employees, who generally receive lower wages and are more apt to work part-time, would also lose, since the high cost of compliance would leave many employers with no choice but to reduce the hours of their least productive employees.

The very characteristics that have made restaurants and other small businesses such a dynamic economic force and the source of millions of entry-level jobs also make them especially sensitive to the labor cost increases that a bill like S. 768 would cause. The restaurant business is a very labor-intensive one. Our industry employs large numbers of young, inexperienced and part-time workers, many of whom would otherwise be without jobs. We employ more teenagers than any other industry, and we have the shortest average workweek (approximately 26 hours) of any industry.

Many of these employees are only marginally attached to the workforce. They may be students with part-time jobs, mothers who work to bring extra income into the household, or retirees who wish to continue to be productive but don't want a full-time job. They are essential to our operations, but most restaurateurs cannot afford to provide them with the array of benefits you propose. Furthermore, many of these workers are dependents who are covered under the health plans of a parent or spouse and do not need additional coverage. For small independent restaurateurs already faced with high payroll costs, the additional expense of providing comprehensive health benefits to all employees--without regard to their benefit needs or level of productivity--is simply prohibitive.

Any major increase in labor costs will be the straw that breaks the back of many of these firms. In studying the Kennedy-Waxman proposal, the Congressional Budget Office determined that businesses might decide either to pass on the higher benefit costs to consumers or absorb the costs by lowering their profit margins. For restaurants, these are not alternatives. Our industry is highly competitive, and there is a limit to the amount of increased labor costs we can pass on to our customers. If all of a sudden it costs $10 for a hamburger, people will no longer buy them. Restaurants compete not only with each other, but also with the cost of food at grocery and convenience stores. In the restaurant industry, passing on costs can be the economic equivalent of suicide. And when many restaurants barely turn a profit in even the best of times, squeezing profit margins is not an option either.

If I may, I would like to give you an example of how out-of-line this legislation is with restaurant business practices. Under S. 768, if the cost of compliance to a small employer exceeds 5% of gross revenues, the federal government will subsidize the excess at a rate of 75%. Mr. Chairman, the 1987 Restaurant Association Industry Operation Report (see page 9) indicates that in 1986 full menu/tableservice restaurants, on average, had before tax income of only 2.4%. It doesn't take a mathematical genius to figure out that an increase in labor costs equal to 5% of sales would sentence these employers to bankruptcy–and their employees to joblessness.

WHAT BENEFITS RESTAURANTS CURRENTLY PROVIDE

The National Restaurant Association conducted a survey among a random sample of 770 members in early 1988. Its purpose was to determine:

- o availability of employer-provided health benefit coverage for industry employees;
- o characteristics of health insurance plans.

The results of our industry survey were very much in line with those of the rest of the business community.

1. More than half of small companies with sales under $500,000 do not provide any health insurance for hourly or salaried employees.
2. Seventy-two percent of restaurant companies with sales of $1 to $5 million provide health insurance coverage for both salaried and hourly employees.
3. Ninety percent of restaurant companies with sales of $10 million or more provide coverage for salaried and hourly workers.

Our research found that the:

- o median waiting period to be eligible is 90 days
- o median weekly hours required for coverage is 30 hours
- o co-insurance rate is 80%

Mr. Chairman, after analyzing your mandated health insurance proposals, it became clear to us that you are attempting to legislate a massive new program without critical information about the needs of workers in our industry. The restaurant business has a unique workforce, which I have already described, and they are not necessarily in need of the same benefits as, say, auto workers.

For this reason our Board of Directors has established a task force that is in the process of designing further research on this subject. We are going to survey our employers again about their experience in providing health insurance for employees, and we are going to survey a cross-section of restaurant workers about their unique benefit needs. To the best of our knowledge, there is very little information available on employee needs in our industry or any other industry.

We think it's important to get answers to questions like the following:

- What benefits does your employer currently offer?
- What benefits do you believe your employer should offer?
- If your employer offers a health insurance plan, do you participate? If not, why?
- Do you have access to health insurance through your spouse or parents plan?

Mr. Chairman, we believe more information will help us help you design a workable system combining private sector incentives for broader health care coverage together with cost effective government-sponsored programs to benefit the unemployed and the poor. We look forward to sharing our data with you and the staff at a later date.

COST IS KEY ELEMENT

Mr. Chairman, one thing we do know is that most companies that do not provide health care cannot afford to do so. If a company can't afford health insurance today, a mandate from Washington won't make it affordable it tomorrow. We also know that most employers that currently provide insurance are experiencing dramatic cost increases.

Senator Hatch has introduced legislation today and has announced his intentions of introducing more in the future which will seek to address these cost problems. We wholeheartedly support his efforts in this area and ask the committee to help him carry them out. The areas where change must be made are:

1. Preemption of state mandates. Currently, all states have laws which require certain types of benefits. These mandates increase the cost of basic health coverage and prevent many employers from providing any insurance at all.
2. Assist states in setting up state-run pools for the uninsurable. Funding these pools with general revenues would spread this societal burden to all citizens.
3. Give all businesses a 100% tax deduction for health insurance. According to the Employee Benefits Research Institute, 22.4% of the self-employed are without health insurance, making up a significant portion of the uninsured.
4. Provide a tax credit for employers who have no taxable income and yet provide health insurance for their employees.
5. Malpractice reform. Malpractice costs are dramatically fueling the escalation of health care costs and something must be done to stop it.

AMERICAN RESTAURANT EMPLOYERS TRUST

In my capacity as a trustee of ARET, I regularly discuss health policy issues with restaurant owners throughout the country. I feel confident in saying that most of them who do not offer health insurance for their employees would like to do so. Many have never had the opportunity. The Trust provides benefits that are not as generous as those you propose. They are, however, tailored to meet the needs of our industry--the employers and the employees. Employers and employees share the burden and find it acceptable. We have just scratched the surface, but are certain we can dramatically expand coverage to more people.

Because of our success, we feel confident that similar health care trusts will follow. Particularly if some of the barriers are removed and costs are restrained. Senator Hatch's proposal will give us the opportunity to reach more people.

CONCLUSION

Mr. Chairman, in closing, I thank you again for this opportunity to present views of the National Restaurant Association. We would like to continue working with you, Senator Hatch and other members of the committee to develop an incentive-based incremental plan to solve this crisis of access to health care. No one wants to duck this very serious problem of health care for all American, but a mandated approach is simply not the answer and will only end up hurting those we are trying to help.

The 1987 Restaurant Association Industry Operations Report indicates the following net income before percentage in 1986 for different categories of foodservice operations.

NET INCOME TAXES, 1986

	Percent
Full menu/tableservice	2.4%
Limited menu/tableservice	6.3
Limited menu/no tableservice	8.2
Cafeteria	6.9

The **Chairman**. Mr. Naylor, what would be the revenue costs for those tax incentives you have indicated you would support—do you know?

Mr. **Naylor**. I am not familiar with the background on all of that; as a restaurateur who makes my living frying hamburgers, I do not have that extensive background. But that is available and will be a part of the Hatch proposal.

The **Chairman**. Dr. Lewin, do you have small restaurants out in Hawaii?

Dr. **Lewin**. We certainly do, and again, their rates would be pooled with all small businesses in the State, so the hardships would really be minimized as compared to what happens with most commercial insurance kinds of experiential rating.

The **Chairman**. Do they survive out there?

Dr. **Lewin**. They certainly do. The sky has not fallen, even though the fears continue to be expressed. And I need to share with people that Hawaii is very comparable.

The **Chairman**. Mr. Sandmeyer, you also indicated a very substantial expansion of the Medicaid program. How much are you willing to support to have that expanded? We are only covering about 40 percent now. That is a rather restrictive program, actually; even under its definition, we are only covering about 40 percent. How much do you think we ought to be spending in that area?

Mr. **Sandmeyer**. Well, Senator, we realize that that is a very, very complex political issue. I believe Senator Hatch estimates a cost of somewhere around $6 billion. Obviously, we're going to have to reallocate funds or talk about some fund of additional revenue increases, longer-term. We fully believe it should be a phased in program. We also feel it is somewhat of a social problem, quite frankly, and as the folks here on this panel this morning have indicated, I think we are all willing to share in this cost in some form. But to have it mandated is not the solution.

The **Chairman**. We have now about five million Americans who are poor who may even qualified for Medicaid who are covered today by their businesses.

Mr. **Sandmeyer**. Yes, sir.

The **Chairman**. What do you think would happen—do you think if those businesses knew that the Feds were going to pick it up, they would continue to cover them, or would they drop it, and that would add another five million onto the taxpayer rolls?

Mr. **Sandmeyer**. Senator, I think that——

The **Chairman**. As a businessman and someone who looks at the bottom line, what do you think the businesses would do?

Mr. **Sandmeyer**. I think we would continue to support and participate.

The **Chairman**. Do you think so, even though you could save yourself a good deal of revenue for your business, and could let the taxpayers pick it up in terms of Medicaid—you think as a businessman, exercising a business judgment, that they would continue to cover them and chip into the profits?

Mr. **Sandmeyer**. Yes, because if it went through the tax system, obviously we would be paying more corporate taxes somewhere along the way.

The CHAIRMAN. Well, I think in manufacturing, the statistics indicate that 98 percent of manufacturers across the country are picking up——

The CHAIRMAN. So why does this program adversely affect our competitiveness internationally if the ones that we are competing with internationally are already covered?

Mr. SANDMEYER. Well, it is going to place a burden on a lot of the small manufacturers who are struggling to survive and be competitive in a worldwide economy, and this would just add increase costs by the very fact that it would be mandated.

The CHAIRMAN. Do you think your premiums are rising because others are not paying their fair share?

Mr. SANDMEYER. Senator, I think it is a combination of things. It is not just one situation. Obviously, health care costs are rising. In our own company, as an example, I indicated we had a 41 percent increase last year. What I did not tell you was that one of our loyal employees, with 17 years of service, had a six-way bypass that cost $185,000, and he died five days later.

The CHAIRMAN. Do you think you are paying for any of the restaurant employees who are not getting any health insurance?

Mr. SANDMEYER. Yes, sir, I'm sure we are.

The CHAIRMAN. That doesn't bother you at all?

Mr. SANDMEYER. No, sir, it does not.

The CHAIRMAN. When you've got restaurants out in Hawaii that are able to pay their fair share—you are glad to pick up from the private sector the premiums for the workers in the restaurants?

Mr. SANDMEYER. Well, I would not use the term "glad", Senator. We feel we have a social responsibility as a corporate citizen of the City of Philadelphia to share in some of the problems of——

The CHAIRMAN. You are not competitive internationally if you find your premiums continuing to go up because you are paying for those who are uninsured. Do you think that is going to help our competitive position?

Mr. SANDMEYER. That is one of the things that concerns us, sir. The Koreans and the Japanese are ready to eat the lunch of our American workers, and we've got to find a way to stay cost-competitive, to compete long-term. I view this as a long-range program of which this discussion this morning is one part of it.

The CHAIRMAN. Yes, Mr. Naylor?

Mr. NAYLOR. If I might, Senator, they have given me the information that you had asked for. To extend the 100 percent deductibility of health insurance benefits to self-employed individuals—and currently, they receive only a 25 percent deduction—and these are really the bulk of the people working in our industry that are self-employed, the small business industry; the other employers, or corporate America, gets 100 percent deduction of those premium costs—that would cost $1 billion.

The CHAIRMAN. I think that is really unfair. That feature of it, I support. I think it is going to be unrealistic unless we are going to have some help and assistance for small business.

Mr. NAYLOR. I think if we level the playing field, Senator, we really would find that those people do want to purchase insurance, and if they have that opportunity, and we do get a level playing field, that so many more of them will do it on a voluntary basis.

Thank you.

The **Chairman**. I want to thank all of you. As I mentioned earlier, I have to go over to the Floor, but I appreciate very much your testimony. We won't overly burden you, but if there are specific questions that members want to ask, we'll invite your response.

[Additional material supplied for the record follows:]

Questions for
Lynn Etheredge

1. Mr. Etheredge, in March 1987 the Census Bureau modified their questions about health insurance in their CPS Survey. The results of that survey are now under discussion in a number of quarters. It seems that in the data released last fall that the number of uninsured are less than the numbers we are hearing. They tell me that it is more like 35.5 million without insurance and that the uninsured rate is 14.7 percent and not the previous 15.7. In light of these findings would you please explain to the Committee how you reach the conclusion that this is a growing problem as you assert in your statement?

2. In your statement you suggest what a positive impact the Chairman's bill would have on the availability of insurance. What would be the ripple effect in our economy? Do you agree that it could result in lost jobs?

3. Mr. Etheredge, I have talked with hospital administrators in Utah who have a lot to gain if everyone has insurance, but a lot to lose if they have to offer a plan that is provided for in S. 768. Just how much do you think this plan would add in expenses to our growing health care cost?

4. Mr. Etheredge, you talk about the competitive trends eroding the insurance market for the small business. It seems to me that what you are proposing will erode the flexibility of individual businesses to compete in a free market. What will be the impact on the insurance industry, or will their be a need for such an industry after the passage of S. 768? Or worse, can we expect to the insurance industry nationalized and run like some of our Federal agencies?

5. Mr. Etheredge, we have just gone through a very heated debate in the Senate on the issue of mandated catastrophic insurance for seniors. I along with every other member of the Congress have been swamped with letters of outrage over this mandate. Why should we think the publics response to the mandates contained in Senator Kennedy's bill will be any less?

6. Mr. Etheredge, almost everyone that has looked at Senator Kennedy's bill has commented on the cost to implement it as it is currently written. What do you think the cost would be for implementation.

7. Mr. Etheredge, you are a very knowledgeable person with a lot of experience in this area. In addition, you have broad experience in the federal service. If you had to develop a proposal that would achieve the same objective---leveling the playing field, and assuring access to health care---but did not want to restrict individual freedom by such a system, what legislative solution would you suggest?

8. Mr. Etheredge, would you please explain to the Committee what factors you see as contributing to the rise in health care cost and your suggestions for dampening each?

9. If we have a national approach as envisioned by S. 768 what protection would there be that a decision would not be made to ration care, restrict transplants to selected individuals, or restrict the use of high tech diagnostic tools by eliminating them from coverage for certain age or population groups?

10 We all know that health care inflation has been rising rapidly and frequently outstripping the CPI. What impact would S. 768 have on health care cost?

11. What would be the impact on minority workers should S. 768 become law, would they be disproportionately impacted?

Lynn Etheredge
Reply to written questions from Senator Hatch
Hearings of June 23, 1989

1. The new CPS survey, with modified questions, reports somewhat lower estimates of the uninsured than previous versions and other studies. But whether the actual number is closer to 37 million, as shown in previous survey and the recent HHS Survey of Income and Program Participation (SIPP), or to the 35.5 million cited in your question, these estimates are all sharply higher than the roughly 25 million uninsured shown by comparable studies in the mid-1970's. A steadily worsening problem is also shown by the annual CPS surveys, as well as by the health insurance industry's own data. The Health Insurance Association of America's reports show the number of persons under age 65 with private health insurance coverage peaked about 1980 and has been declining through this decade. So, while there are some relatively minor differences in measures of the current problem, the trend data are unequivocal and show that the number of uninsured are an increasingly serious matter for national concern.

2. Overall, the health insurance costs would be a small percent of payroll, and special provisions are made for expenses above a five percent threshold. Economic theory suggests that there could be some slight, temporary slowing in the rate of growth of money wages for some workers if employers have to pay more of their compensation costs in health insurance benefits. But economy-wide ripple effects from such small changes in an economy producing $5 trillion of goods and services each year will hardly be noticeable. In today's steadily growing economy, which offers many more jobs each year, my judgement is that there would be minimal effect on employment. I understand that several careful studies, which were the subject of hearings last fall, also reached similar conclusions.

3. There is something truly objectionable about hospitals which do not give their employees basic health insurance benefits. Hospitals are among our society's largest and wealthiest institutions, and are usually among a community's leading employers. Given the salaries hospitals pay their administrators, and their physicians' incomes, they can certainly afford to provide basic benefits for their

workers. Their workers, more than any other, are also daily exposed to the risk of serious infectious diseases and need this protection.

Overall, this bill's expense would have a very small effect, perhaps 3%, on national health spending. Most Americans, however, would stand to gain from the reduced cost-shifting. Added costs would be paid primarily by the employers -- such as the hospitals cited in your example -- which have not been doing right by their employees and have been enjoying a free ride at the expense of the rest of us.

4. For most businesses, this legislation will have barely noticeable effects, such as a few cents on the average restaurant meal bill, so there won't be much shifting of businesses among firms. Indeed, the legislation should strengthen competition in two major respects. First, it will level the playing field so that firms can no longer be free-riders and have unfair competitive advantages -- lowering their own costs (by not paying health insurance) and raising their competitors' costs (through the higher insurance premiums they must pay to cover the uninsured). Second, labor market mobility should be strengthened, particularly to the benefit of attracting skilled workers, including older workers and disabled persons, into the growing small business sector. These workers now should be reluctant to make such job changes in light of the many new underwriting restrictions, exclusions of pre-existing conditions and premium rating practices for health insurance described this morning.

For the health insurance industry, this legislation offers an unparalleled economic opportunity for $15-20 billion of new health insurance business in a period when health insurance coverage in declining and they have been losing money. Competition among health insurers is a central concept of this legislation -- but it would be competition focused on controlling health care costs and better service -- not on risk selection and refusing health insurance to individuals who need such coverage.

5. My understanding is that the objections to the Medicare catastrophic insurance bill are not to the benefits -- which the elderly have wanted -- but to the fact that the financing burden falls very heavily on only a small, well-off and vocal part of the elderly population. I think this legislation would enjoy broader

public support in our society, since its goals are to assure basic benefits for those with no coverage, as opposed to supplementary benefits for those already with good coverage. Similarly, the financing burdens will be fairly allocated, primarily to employers, the same way nearly all workers now get their benefits, and they will be relatively small and affordable in terms of total employer costs.

6. Our current health care system is extraordinarily expensive to administer. Studies show that total administrative expenses are over 20% of total spending, i.e. more than $100 billion annually, and that these expenses have led the rise in health care spending. Nowhere are such added costs more troublesome than in the higher costs of small business coverage compared to large employers. By simplifying this market, standardizing benefits, and focusing marketplace competition on cost reductions rather than underwriting practices and risk-pool skimming, there should be far less waste in this market. There will certainly be some start-up expenses but a net savings in total administrative expenses are among this bill's strengths.

7. One can come up with a lot of different designs for national health insurance -- Canadian, British, West German, plus other measures based on different philosophical preferences and/or economic theories. But the foreign models and the major comprehensive U.S. proposals all require vastly more government regulation -- and government spending -- than this legislation. None of them have a realistic chance of enactment. Moreover, all of these designs require balancing individual freedom of choice with the necessity for grouping individuals into insurance pools so that risks are shared. Even the well-known "consumer choice" proposal that aims to increase freedom by giving vouchers to individuals requires standardized benefits, community rating and open enrollment. Of all the possibilities, S. 768 involves just about the least amount of new federal regulation and spending that is needed to solve this problem.

8. The reasons for rising health care costs, and the ways to deal with them, go far beyond what can be covered here. Basically, rising health care costs result from many public and private sector arrangements that emphasize the importance of improving health care technology, resources and financing to get first-rate, affordable health care for our population. These include very large

investments in biomedical science (the U.S. government funds about 80% of the world's public spending for this purpose, primarily through NIH), an expanding (and increasingly specialized) physician supply, and major financing subsidies through government programs, employer contributions and tax policies. Despite the amount of talk about health care costs, they have been a secondary (or tertiary) concern. We need reforms that can eliminate what is unnecessary in health expenditures, without impairing worthwhile advances in medical care, and assure access, without rationing, to first-rate affordable care for all our citizens. The health services research literature shows that three basic cost control measures are effective, but each deals best with only part of the problem and, if not used well, can have drawbacks or just "balloon" cost increases elsewhere. Regulation can deal with price increases. HMOs and managed care effectively reduce inpatient hospital use. Cost-sharing, per the Rand experiment, has a major impact on ambulatory use. So a fully-effective national strategy will best use all three approaches. As well, I think that changing our physician payment methods, by adopting a resource-based fee schedule, will also prove essential. Physicians control 70%-80% of health care expenses, so getting the economic incentives right for these key decision-makers -- correcting the overpayments which foster the most expensive inpatient hospital and technology-intensive services and correcting the underpayments for primary care, preventive, conservative and less inflationary treatment patterns -- seems a critical step to a more effective national strategy.

9. The greatest risk of rationing care -- indeed, the certainty that it will occur -- is to have roughly 35 million persons without any health insurance care at all. We already know from surveys and reports that health care is rationed for the uninsured -- that, without health insurance, a father and mother must raise $100,000 through public appeals just to get a needed kidney transplant for a young child before a hospital will consider putting the child on a waiting list, that L.A. county hospitals (and others) have been closing emergency rooms rather than foot the bill for meeting the urgent medical needs of those without health insurance. One of the advantages of this legislation is that it will end such rationing that now occurs for more than 20 million workers and their families so that these Americans, who work full time to support their families, can also be sure that they will be able, like the rest of us, to get needed medical care. If we do not

have this legislation, and the numbers of uninsured continue to rise, it is predictable the rationing of health care will increase. Those who are concerned about health care rationing should support this legislation.

10. As I indicated earlier (Question 3), the legislation would save money (or have no noticeable effect) for most Americans. Added costs would be targeted on the "free-riders" who are not now paying these costs and are shifting them to the rest of us. Overall, the expenses would be less than 3% of national spending. In terms of health cost inflation, it is the spending policies for the current $500 billion plus of services annually -- what Medicare and large employers do (or do not do) to contain costs -- that will primarily determine the rise of their own expenses.

11. Low wage workers are among the major beneficiaries from this bill -- it will, for example, help to build a complete bridge from welfare assistance, with Medicaid benefits, into productive, full-time work, with health insurance benefits. Now, one of the major economic barriers to individuals moving from welfare into full-time employment is that they can be much worse off because of losing health insurance coverage. So S. 768, along with Medicaid reforms, the minimum wage and earned income tax credit, has an important part to play in assisting many individuals, including minorities, in becoming employed, fully productive and self-supporting workers.

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NATIONAL
RESTAURANT
ASSOCIATION

August 4, 1989

The Honorable Orrin Hatch
United States Senate
Committee on Labor and Human Resources
Washington, DC 20510-6300

Dear Senator Hatch:

Following are the answers to the questions you submitted as part of the hearing record for June 23 on S. 768, the Basic Health Benefits for All Americans Act.

1. Mr. Naylor, I would like to ask you about the American Restaurant Employers Trust. As I understand you offer your program in a variety of states some of which have a large menu of mandated coverage. Have state mandates had an impact on the insurance that you offer. Do you offer the same package of benefits in each state where your plans operate?

   ANSWER:

   The American Restaurant Employers Trust offers the same basic coverage in all of the states where our plan operates with managed care products available where applicable. Thus far, for those who already purchase insurance, we have been able to comply with the state mandates. There is, however, a problem with employers who can not afford the coverage we presently offer. If we, and others, could offer a scaled-down catastrophic package, or a plan with scheduled benefits, for example, that would allow marginally profitable employers to enter the market, it would be a first step towards expanding health insurance to many more workers and employers. Statistics indicate that the more stable a business becomes, the better the benefit packages offered to employees become. By removing the state mandates and allowing employers to offer a less expensive, more basic health insurance package, employees could begin receiving at least some type of coverage at an earlier point in the growth cycle of a business with more expansive coverage to follow in the future.

2. Mr. Naylor, I have been told by a number of small business leaders that they fear anti-trust action as a result of forming multiple employer trusts. For the record, I have been advised by the Justice Department that such an action is not an anti-trust violation. In addition, I expect to receive a written confirmation of this opinion shortly. When you were forming your trust, did this issue cause any concern?

   ANSWER:

   When we gathered in 1975 to provide a quality health insurance plan for restaurateurs in southern California, we did not fear that our actions could be interpreted as an anti-trust violation. We were a group of people in a common industry who joined together to set up a common program that was fully authorized under ERISA and other insurance codes.

3. Mr. Naylor, in your statement you noted that the average before tax income of restaurants is only 2.4%. Clearly, those on the low end of average are going to have a difficult time paying for comprehensive health benefits. If we provided a tax credit for health insurance to those without taxable income how much would we expand the number of owners offering insurance?

ANSWER:

As you know, Senator Hatch, I am a restaurant operator and agent for the American Restaurant Employers Trust. I am not a statistician and do not have data available that would estimate how many restaurant operators would provide health insurance if a tax credit were provided for those without any taxable income. I do know, however, that many new businesses just starting out may not turn a profit for several years. For them, providing health insurance is simply out of the question and even allowing the 100% deductibility of the premiums would not serve as a true advantage. Many of these operators would like to provide insurance for themselves and their employees and a tax credit could make the difference in whether or not they chose to do so.

4. Mr. Naylor, in your statement you are supportive of establishing insurance pools for those with uninsurable conditions. One of the questions about such approaches to the uninsurable is how to reach this population and help them to use that which is available. Do you think that trusts like yours would be willing to serve as an agent for your members to offer coverage to those that you would not normally insure?

ANSWER:

I do not believe it will be at all difficult to reach the uninsurable population to inform them that insurance coverage, which they have all been waiting for, is finally available. Those who can afford insurance will seek it out as soon as possible. Secondly, a trust like ours would be very willing to administer a trust that provides such coverage, if and only if, it were operated totally separate from the plan we now offer. Our trust has been able to survive and thrive because of strict underwriting practices. To include the uninsurable, who have been left out on purpose because of the risk they bring with them, would pose a serious threat to the viability of our trust and others presently operating throughout the country. From my experience, the main problem you will find in establishing insurance pools for the uninsured is finding a carrier who is willing to underwrite the risk, not finding an administrator for it.

5. Mr. Naylor, have you done any cost figures to determine what it would cost you to offer a program like that required by the Chairman's bill?

ANSWER:

Senator Hatch, the Third Party Administrator of our trust, Corroon and Black Benefits Inc., has contacted several underwriters about the cost of providing coverage under the Basic Health Benefits for All Americans Act. The estimates on initial premiums range in the neighborhood of $2,500 to $3,000 composite rate per employee. These underwriters agree that future premiums cannot be predicted mainly because no exclusions for preexisting medical conditions would be allowed.

I hope you find this information helpful and that you will not hesitate to contact me or our staff if we can be of further assistance. Thank you for your consideration and your efforts to bring about an incentive-based solution to the problem of the nation's uninsured.

Sincerely,

Bill Naylor

W. W. Naylor, Director
National Restaurant Association

July 19, 1989

TO : Senate Committee on Labor and Human Resources

FROM : Mark Merlis
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : **Questions Submitted by Senator Hatch**

The following is in response to your letter of July 6, 1989, which transmitted Senator Hatch's questions relating to my testimony on June 23, 1989. As you can see, in each case we have repeated his questions to me, followed by my response.

1. In your statement you note that there is controversy over the effects of State mandates on the cost of insurance. Are the costs of these mandates preventing insurers from offering products that might be more affordable for small employers, and is there evidence that employers are dropping or not offering health care coverage because of these mandates?

In considering the impact of State mandates on the cost and availability of health insurance, it may be useful to distinguish between two kinds of potential effects. First, some mandates may increase the costs of conventional health insurance plans. Second, some mandates might prevent insurers from offering innovative plans, such as catastrophic-only coverage, that are very different from those ordinarily available in the insurance market.

There is debate over the extent to which mandates increase the cost of conventional insurance plans. While some studies have estimated that mandated benefits may account for as much as 17 percent of the cost of a plan, other analysts have argued that mandates may increase plan costs by as little as 2 to 5 percent. Still, in combination with other factors, mandates may help to increase costs to the point that some employers may find coverage too expensive. Employers themselves do not perceive State mandates as an important factor. In a 1986 survey performed for the Small Business Administration (SBA), only 1 percent of employers who did not offer coverage cited the impact of State mandates as one of the reasons for their decision. However, mandates may have been an indirect factor for the 62 percent of these employers who identified cost as a major barrier to coverage.

The effect of mandates on insurers' ability to offer innovative types of health insurance policies is less certain. Although mandates are often cited as preventing insurers from developing catastrophic-only plans (that is, plans with a very high deductible), it is not clear why this should be so. While States have required that insurers cover certain types of services, such as mental health care, or services of certain practitioners, such as psychologists or chiropractors, States have not mandated first-dollar coverage of these services. An insurer could offer a high-deductible policy, provided that the mandated services were covered after the deductible was reached.

2. In your statement you indicated that small employers may pay from 10 to 15 percent more for health insurance than larger employers. You also go on to note that this increased cost is not attributable to differences in the cost of benefits. In this day of computer billing and record keeping, including direct billing by pharmacists and physicians to insurance companies, is this difference in cost justified?

Administrative costs for very small group plans may be as much as 40 percent of claims (benefit) costs, as opposed to 5.5 percent in the very largest conventionally insured groups. The factors cited in the question relate to costs for actual processing of invoices. These are only one component of the total cost of administering a plan, and are not the most significant factor in the differences in costs for small and large groups. Table 1 gives estimates, by group size, of the components of administrative cost. As the table indicates, while claims administration costs decline with the size of the group, components such as the risk and profit charge and marketing commissions drop even more sharply for the largest employers. The new billing practices mentioned in the question might eventually narrow the gap in claims processing costs for small and large groups. (It should be noted, however, that providers may enter into direct billing arrangements only with a few insurers who cover a substantial share of their patients; these insurers may not have a large share of the small business market.) Even if this gap could be reduced, there would remain large differences in other administrative costs.

TABLE 1. Administrative Expense Breakdown for Conventionally Insured Plans (Expressed as a percent of incurred claims)

Number of employees	Claims admin.	General admin.	Interest credit	Risk and profit	Com-missions	Premium taxes	total
1 - 4	9.3	12.5	-1.5	8.5	8.4	2.8	40.0
5 - 9	8.6	11.2	-1.5	8.0	6.0	2.7	35.0
10 - 19	7.2	9.2	-1.5	7.5	5.0	2.6	30.0
20 - 49	6.3	7.6	-1.5	6.8	3.3	2.5	25.0
50 - 99	4.3	4.8	-1.5	6.0	2.0	2.4	18.0
100 - 499	4.1	4.0	-1.5	5.5	1.6	2.3	16.0
500 - 2,499	3.9	3.2	-1.5	3.5	0.7	2.2	12.0
2,500 - 9,999	3.8	1.4	-1.5	1.8	0.3	2.2	8.0
10,000 +	3.0	0.7	-1.5	1.1	0.1	2.1	5.5

Source: U.S. Library of Congress. Congressional Research Service. Cost and Effects of Extending Health Insurance Coverage. Report prepared for the House Committees on Education and Labor and Energy and Commerce and the Senate Special Committee on Aging. Washington. October 1988. [Education and Labor serial no. 100-EE; Energy and Commerce serial no. 100-C; Special Committee on Aging serial no. 100-P] p. 46. Estimates by Hay/Huggins Company based on underwriting practices of major insurers.

3. What has been the effect of the COBRA mandates on the cost of health insurance?

Full information on the impact of COBRA is not yet available. The continuation of coverage provisions have taken effect at different times for different groups, depending on the start date of the individual group's plan year and the expiration date of existing collective bargaining agreements. As a result, some groups have not yet completed their first full year under the new provisions. (There may even be groups covered by collective bargaining agreements for which COBRA still has not taken effect.)

There have been some preliminary attempts to measure the impact of COBRA through surveys of affected employers, chiefly surveys by benefit consulting firms of their own clients. These surveys tend to reflect the experience of larger employers. Even among large firms relatively few have collected data on the proportion of COBRA eligibles opting for continuation coverage, or the costs for this coverage relative to those for active employees. The most recent study known to us is a 1989 survey of 103 firms by Charles D. Spencer & Associates; only 45 firms could provide full information. The average firm reported that costs for continuation coverage were 176 percent of costs for active employees. Costs for COBRA eligibles who elected coverage were the same in small and large firms, but more of those who were eligible in small firms chose to obtain the coverage.

This and previous surveys found considerable variation among employers in the cost of claims for COBRA eligibles, as well as in the administrative costs associated with continuation coverage. Given the amount of variation and the small sample size, it is not certain that these studies can be generalized to the entire insured population. Larger and more systematic surveys may be required before the real cost impact of COBRA can be determined.

4. I am on record that we must do everything we can to reduce health care cost. Can you give the Committee a brief description of why health care costs are rising at 2-3 times the rate of inflation?

While there is no single explanation for the growth in health care costs, there is a consensus that several factors have played a role; the relative importance of these factors remains in dispute. The following is a simple listing of some of the forces believed to be contributing to cost increases.

- The adoption and rapid proliferation of costly new medical technologies.

- Aging of the population. This factor contributes to growth, not only in Medicare expenditures, but also in the costs of employee health benefits in industrial sectors, such as heavy manufacturing, with an aging workforce and a growing retiree population.

- Procedure-intensive practice patterns. Growth in the volume of diagnostic and surgical procedures is attributable in part to the practice of "defensive medicine," but may also reflect an attempt to compensate for restraints on the prices of individual services. Intensive practice styles may also stem from physicians' professional training, which may emphasize technological approaches. Finally, patients with increasing sophistication about medical care may demand more intensive services.

- Excess supply. While oversupply in other economic sectors leads to price reductions, oversupply in the health care sector may contribute to increases in the volume of services furnished. Some studies have shown that this is true in areas with a high physician/patient ratio. At the institutional level, oversupply brings higher unit prices (fixed costs are spread across fewer patients) and may also result in some compensatory volume increases. The rapid growth of inpatient mental health services and outpatient hospital services of all kinds may be related to the declining volume of medical and surgical admissions.

5. What role do you think insurance plans should play in helping the small employer restrain cost increases?

Cost increases can be restrained in at least three ways: by reducing the scope of services covered, by excluding or limiting coverage for high-cost enrollees or groups, and by controlling or monitoring the services actually furnished, through the various techniques known collectively as "managed care." Managed care under conventional insurance plans may include such practices as pre-admission review, requiring that certain surgical procedures be done on an outpatient basis, or requiring a second opinion before elective surgery. The term is also used to refer to the development of structured health care delivery systems, such as health maintenance organizations (HMOs).

The first two cost-saving approaches, benefit limitation and medical underwriting, have been adopted extensively in the small group market. Managed care approaches, however, remain less common in health coverage for small groups than for larger employers. Table 2, drawn from the SBA survey cited earlier, indicates that employees in larger firms in 1986 were more likely to be in plans that include utilization control measures, and were much more likely to be offered an HMO or PPO option as an alternative to conventional coverage.

TABLE 2. Percentage of Employees in Health Plans Whose Employers Have Taken Various Cost Containment Measures, by Firm Size (1986)

	Employment Size of Firm				
	1-9	**10-24**	**25-99**	**100-499**	**500+**
Second surgical opinion	27	29	41	52	56
Outpatient surgery	24	25	24	49	56
Utilization review	5	3	5	15	43
HMO/PPO	4	6	10	26	44

Source: ICF Incorporated. Health Care Coverage and Costs in Small and Large Businesses. Prepared for Office of Advocacy, U.S. Small Business Administration. Washington, April 15, 1987. Table V-2.

It is possible that there is a shortage of managed care plans available to small employers. Some Federally qualified HMOs, those subject to the requirements of the HMO Act (Title XIII of the Public Health Service Act), may have been discouraged from entering the small group market because, unlike commercial insurers, they may not engage in medical underwriting and are limited in the extent to which they can develop special rates for small groups. It is not clear why conventional insurers in the small group market have not adopted utilization review and other managed care measures. Encouraging the inclusion of managed care features in more small group policies might be one step that insurers could take to reduce costs for small employers. However, the extent to which these control measures actually achieve savings remains in dispute.

6. In your statement you note that to achieve 100 percent participation as required by the insurance companies employers must limit the share of premiums paid by the employees themselves. Is this because low income employees can not afford the premium? Does this lead to employers just not offering insurance?

Insurers that impose minimum participation requirements on small employer groups do so because they are concerned about "self-selection" by members of the group. If enrollment is voluntary and the enrollee must pay part of the cost, employees who anticipate a need for health services may be more likely to join than employees who do not expect to need medical care. As a result, the insurer's costs for the older and sicker members of the group may not be offset by the lower costs for the healthier members. This self-selection may be more likely among low-income employees if the contribution they must make to the cost of coverage is large. Only those most in need of insurance may be prepared to pay the cost. It is for this reason that some small group policies require employers to pay the entire premium.

Minimum participation rules are just one of a variety of factors that can make coverage more costly for small employers. It is difficult to single out any one of these factors as critical in an employer's decision about whether to offer insurance. It should be noted that, if insurers did not impose these rules, the per capita premiums for small group insurance would increase, because the whole pool of small groups would contain fewer healthy and more sick enrollees. Employers with low participation rates would save money, because they would pay no premiums at all for some workers; those with higher participation rates would pay more for each participating worker. The net cost effect of minimum participation rules is therefore difficult to isolate.

7. In your statement you note that a change in current tax policy with regards to medical insurance would only be significant for the very smallest business. What segment of our business community produces the most jobs, isn't it the small businesses? Don't you think that they need every bit of assistance that they can obtain?

The discussion of tax policy in the statement was addressed to the issue of whether a change in the tax treatment of health insurance would be likely to have a significant impact on the number of persons receiving employment-based insurance coverage.

Under current law, a sole proprietor may deduct as a business expense the entire cost of health insurance for employees, but only 25 percent of the cost of coverage for his or her own family. Table 3 illustrates the effect of this rule on the after tax cost of health insurance for sole proprietorships of different sizes, and shows how the after tax cost would change if the proprietor could deduct the entire cost of his or her own insurance. Because there would be no change in the tax treatment of premiums paid for employees, the relative difference in after tax costs shrinks as the firm grows. A self-employed person who employs no other worker pays almost 30 percent more under current law than he or she would under a full deductibility rule. A proprietor with 10 workers, however, pays less than 3 percent more under current law than under full deductibility.

TABLE 3. Illustration of After Tax Cost of Health Insurance for Sole Proprietorship by Number of Employees, Current Law and with 100 Percent Deduction for Owner and Family

Number of employees	Annual premium cost for owner	Annual cost for employees	Total cost	After tax cost, current law	After tax cost, 100% deduction	Percent difference
0	1,200	0	1,200	1,116	864	29.2%
1	1,200	1,200	2,400	1,980	1,728	14.6%
2	1,200	2,400	3,600	2,844	2,592	9.7%
3	1,200	3,600	4,800	3,708	3,456	7.3%
4	1,200	4,800	6,000	4,572	4,320	5.8%
5	1,200	6,000	7,200	5,436	5,184	4.9%
6	1,200	7,200	8,400	6,300	6,048	4.2%
7	1,200	8,400	9,600	7,164	6,912	3.6%
8	1,200	9,600	10,800	8,028	7,776	3.2%
9	1,200	10,800	12,000	8,892	8,640	2.9%
10	1,200	12,000	13,200	9,756	9,504	2.7%

Source: Congressional Research Service analysis.

Note: Illustration assumes $1,200 annual premium per enrollee and self-employed proprietor in 28 percent tax bracket.

A change in current policy, then, would be more likely to affect the insurance purchasing decisions of proprietors with no employees, or with only one or two. As a result, the total number of workers newly covered might be limited. However, there are arguments for changing the current policy even if the change does not have a major effect on health coverage. Proponents of a change contend that current law is inequitable and that it may distort business decision-making by creating an incentive for incorporation by businesses that might otherwise have remained sole proprietorships.

From: John Lewin, M.D.
Re: Responses to Questions Submitted by Senator Hatch

STATE OF HAWAII
DEPARTMENT OF HEALTH
Director's Office

State Health Insurance Program

1. Cost of Administration. State and private sector roles are very different and should not be compared. Our State Health Insurance Program will maintain oversight capabilities of budgeting, planning, monitoring, evaluation and policy development. We also believe that program administrations will also include eligibility determination. As such, these costs will be limited to between $200-250,000 per year, once the program is in operation. The vast majority of administrative functions (claims, processing, payment, provider relations, etc.) will be assumed by the private sector as part of the overall contracts with health insurance companies. As such we do not believe the administrative costs are comparable between public and private sectors.

2. Estimates made by the Hawaii State Department of Human Services, our State's Medicaid agency, are that our Medicaid costs in state funds would go from about $250 million to $271 million. This cost estimate is made on the basis of 12,000 additional persons and 100% of poverty level participating in the program. However to do this would require the state to also raise its level of eligibility for AFDC, a much more expensive proposition. With respect to "buy-ins" by the poor, the specific parameters of the "buy-in" would determine the relative cost benefits of this alternative. While we do not propose "buy-ins" to Medicaid, we have written into our insurance plan the power to transfer funds to the Medicaid program whenever such a transfer provides a cost-effective alternative to our State Health Insurance Program. This alternative may be used for example, to provide Medicaid to children born after September 1983 below 100% of poverty level.

3. Variation in Insurance Package Sold Under SHIP. Our program is presently in the design phase, but we expect at least two or three insurance providers to participate. Our objective is to require that a basic package of benefits, emphasizing prevention and primary care services, is available in all programs contracting with us. Competition among insurers would result in additional benefits over and above our basic package. We do not know the extent of variation this will result in. While these packages will likely be capitated, we expect substantial participation from the provider community.

4. Redesign of Program. Since our program is in the design phase, with significant flexibility given to us by our Governor and State Legislature, we believe we can effect a major new program that is efficient and effective by its start-up date of March 1, 1990. Nothing is perfect, and we expect problems will arise which will require redesign. The flexibility of our enabling legislation is a plus which will enable any necessary redesign to be rapidly undertaken.

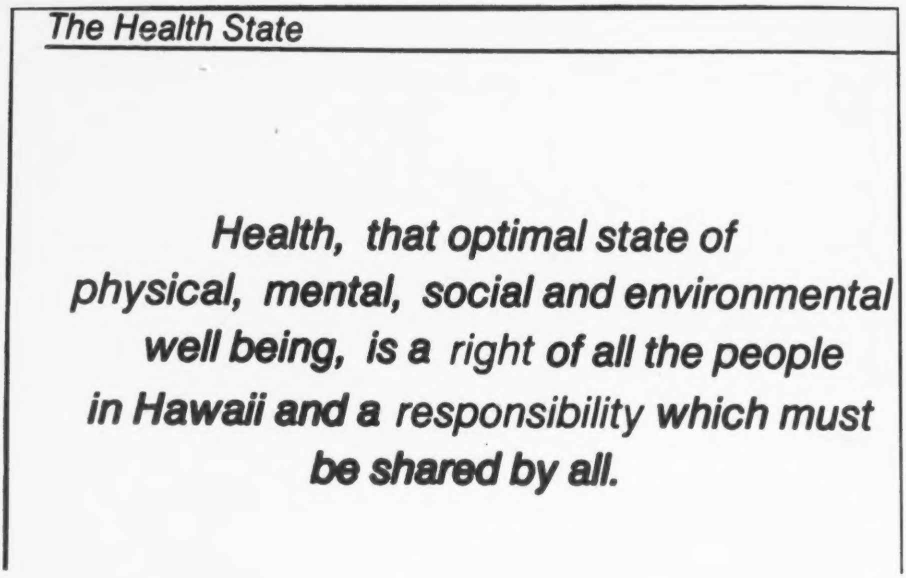
   One redesign problem outside of the State Health Insurance Program which could be of benefit to the program and to other states as well would be the dropping of the ERISA restriction that states cannot require mandated employee based insurance. Hawaii has an exemption from these provisions, but one that does not allow us to alter our law as passed in 1974-both employers and consumers feel some changes would be beneficial. We felt that, with Federal legislation such as Senator Kennedy's bill providing a "safety net," states could and should be able to use this mechanism of employer mandates to provide a higher level of access for their citizens.

5. The two major health programs in Hawaii are those offered by the Hawaii Medical Service Association (HMSA) (a Blue Cross affiliated non-profit organization) and the Kaiser Permanente Health Plan (also non-profit.) Rates for these group Plans are listed below.

	Single Person	Family
HMSA	94.24/mo.	282.72/mo.
Kaiser	72.68/mo.	218.04/mo.

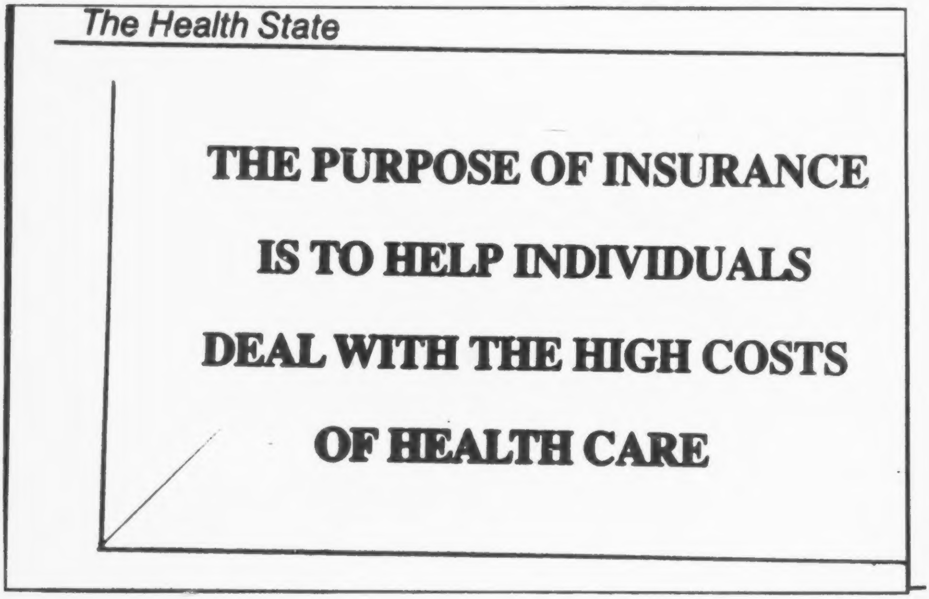
   The amounts of these costs shared by employer and employee will differ with varying collective bargaining arrangements. For "non collective bargaining" arrangements the provisions of our Prepaid Health Care Act (attached) would hold.

Attachment



The Health State

Health, that optimal state of physical, mental, social and environmental well being, is a right of all the people in Hawaii and a responsibility which must be shared by all.



The Health State

THE PURPOSE OF INSURANCE IS TO HELP INDIVIDUALS DEAL WITH THE HIGH COSTS OF HEALTH CARE

e Health State

Dept. of Labor and ndustrial Relations	Prepaid Health Care
Dept. of Human Services	Medicaid
Dept. of Health	State Health Insurance Plan

The Health State

- ● *Prepaid Health Care Act*
- ● ***Medicaid program***

The Health State

- ***Adopted in 1974***
- ***Health insurance/Medical protection assurance for most employees***
- ***Administered by the Department of Labor and Industrial Relations***

The Health State

- Nation's only state mandated benefits pla
- Employers required to provide health insurance
- Employer/employees share cost
  - Employee pays up to 1.5% of wag
  - Dependent coverage optional

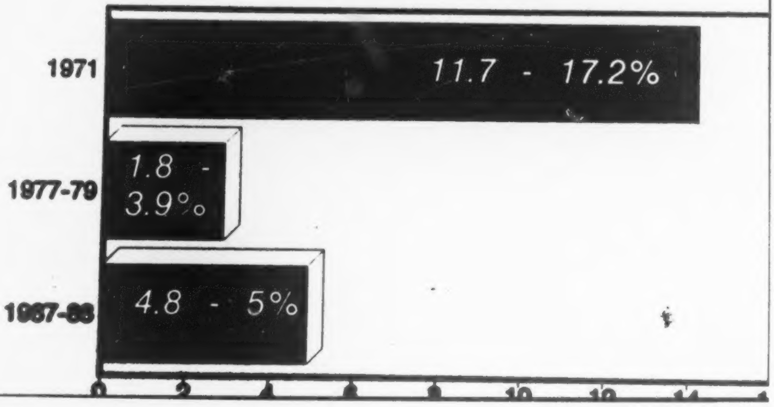
The Health State

- Work 20 hours per week
- Earn 86.67 x minimum hourly wage per month

The Health State

- Government employees (have own plan)
- Seasonal agricultural workers
- Salespersons working on commission
- Small family business - family members
- Government assistance program recipients
- Dependents (optional)

The Health State



The Health State

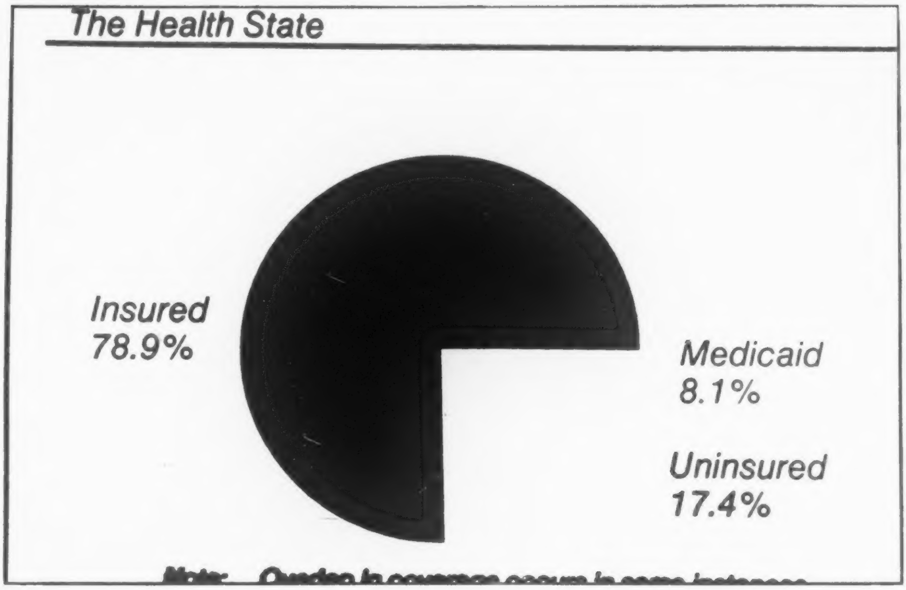
- Beneficiaries - 67,000 persons
- FY 1990 budget = $250 million
- Administered by Dept. of Human Servic

The Health State

- **Hawaii resident**
- **U.S. citizen/permanent resident**
- **Income below 62.5% federal poverty level**
  - **Individuals = $357/month**
  - **Family (4) = $725/month**
- **Asset limitations:**
  - **$1,000 for most categories**
  - **$1,800 - $2,800 for SSI**

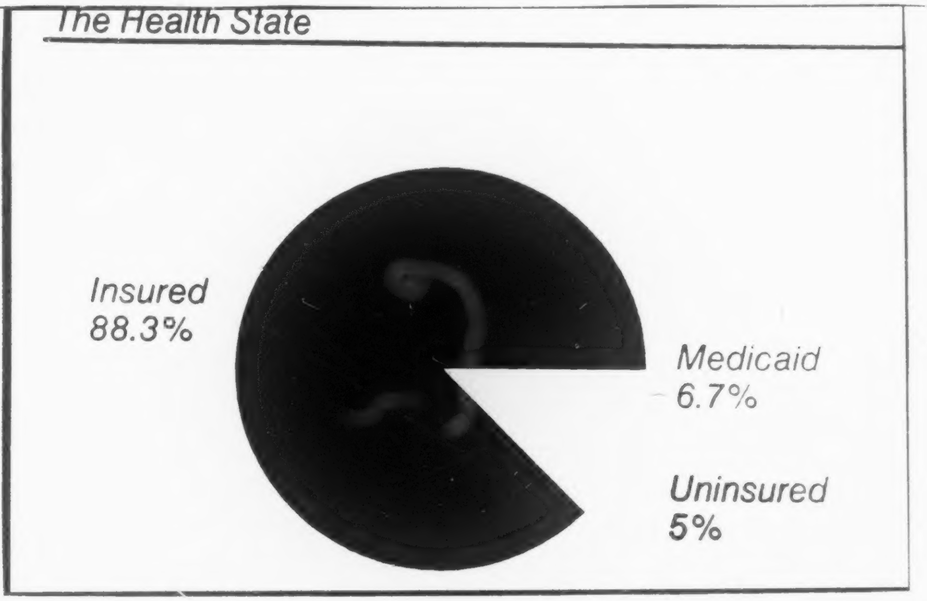
The Health State

- ***Inpatient/outpatient services***
- ***SNF/ICF***
- ***Ancillary***
- ***Physician services***
- ***Thirteen other service categories***

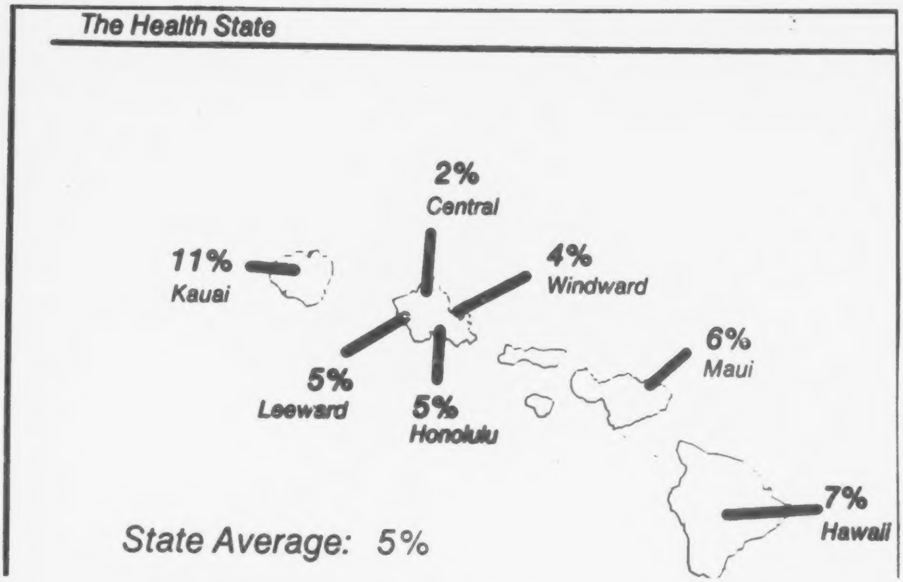


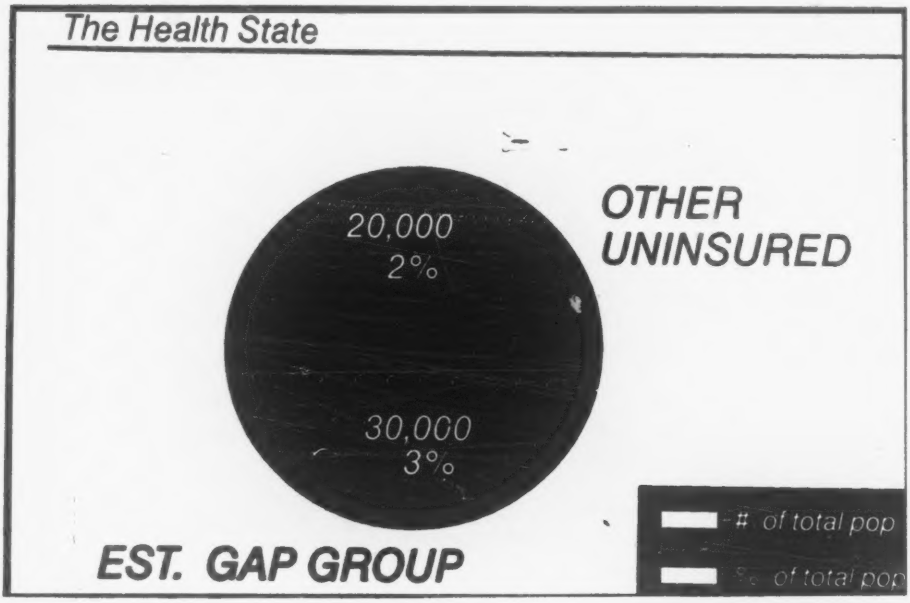
The Health State

Note: Overlap in coverage occurs in some instances



The Health State


The Health State
2%
Central
11%
Kauai
4%
Windward
6%
Maui
5%
Leeward
5%
Honolulu
7%
Hawaii
State Average: 5%


The Health State
20,000
2%
OTHER
UNINSURED
30,000
3%
# of total pop
% of total pop
EST. GAP GROUP

The Health State

Provides universal access to basic health c service to all of Hawaii's people by building upon Hawaii's Prepaid Health Care Act an Medicaid

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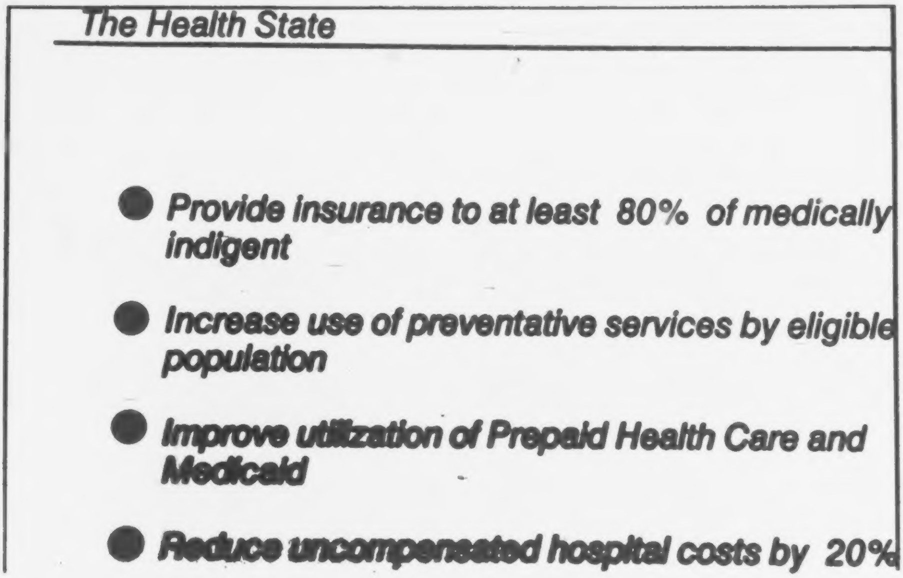
The Health State

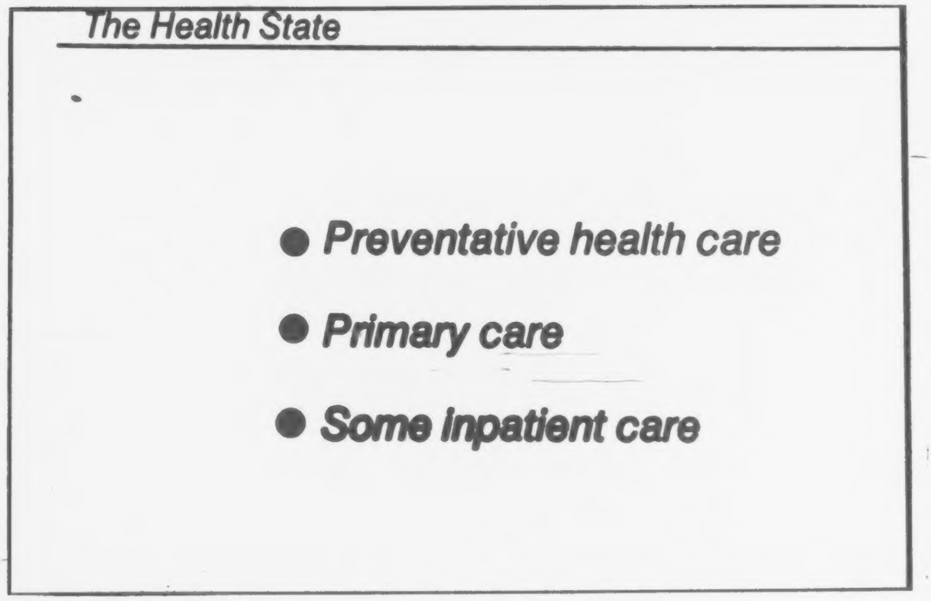
Partnerships:
government, individuals/families, private sector

- **State to subsidize eligible individuals/families insurance cost**
- **Health insurance companies provide coverage**
- **Healthcare providers deliver direct care**



The Health State

- *Provide insurance to at least 80% of medically indigent*
- *Increase use of preventative services by eligible population*
- *Improve utilization of Prepaid Health Care and Medicaid*
- *Reduce uncompensated hospital costs by 20%*



The Health State

- *Preventative health care*
- *Primary care*
- *Some inpatient care*

The Health State

- *Unemployed (30% of Oahu's uninsured)*
- *Dependents of low-income workers*
  - *women*
  - *children*
- *Part-time workers*
- *Seasonal workers*

The Health State

	Per person annually
● *Average state subsidy*	*$500*
● *Average insured share*	*$200*

— *monthly fee (sliding scale to $60)*
— *copayment made at time of visit*

The Health State

Insured ------- Affordable, basic health care

Business ------- No additional costs

Priv. insurance --- No cost shifting to priv. insura

Government ----- Reduce Medicaid costs

Society ------- Healthy

The Health State

Questions for
Jane Ramshaw-Reed

1. Ms. Ramshaw-Reed, would please describe the type of clients that you serve, what percentage are individuals and what percentage are group insurance clients?

2. Ms. Ramshaw-Reed, are you representing your own views or those of an organization?

3. Ms. Ramshaw-Reed, you commented in your statement that having COBRA extension employees in your plan was akin to having one of the big five diseases in your plan. Because only unhealthy individuals take the COBRA option. Tell me, could we shorten the time period for people to take the COBRA mandate if we had an option of more affordable insurance?

4. Ms. Ramshaw-Reed, in your statement you have made a compelling argument for the use of insurance agents as a key part of the insurance puzzle. In my bill I propose to support the development of pools for the uninsured. Do you think such pools should be administered by the state or would they best be done by agents like yourself?

Question 1

I serve a broad range of individuals and groups, with about 20 percent individual and 80 percent small group clients.

My client base includes both individuals and businesses,including hotels, restaurants, doctors, manfacturers, CPA's computer software designers, landscape architects, and bowling alleys. Most of my clientele are entrepreneurs that own their own businesses. As I stated in my testimony, I have been in this business for 17 years and I earn all of my income from the sales and service of group and individual health insurance. I do not sell any related product lines such as individual life, disability, property, or casualty insurance. I also derive additional income from speaking engagements to insurance agent groups teaching agents how to sell health insurance. I have produced a four-cassette taped program entitled, "How to Make Money Selling Group Health Insurance -- Sickness Insurance Made Simple," which I would be glad to send you if you need further information on how agents sell and service this product.

Question 2

Senator Hatch I am representing my own views in this testimony and not that of any organization. Please allow me to introduce myself since I was asked to testify as an expert witness.

My background in this industry for the last 17 years is related in my testimony. I have been extremely active within my professional organizations, both as a member and a leader.

I am a member of the National Association of Life Underwriters which has a membership of 139,000 across the United States. I am past president of the San Diego Chapter (membership 1,000). I have served on the Board of Trustees for two years as the chairman of the Health Insurance Committee at the national level.

In addition to these leadership positions I was number one in the United States for my size category in membership for my local association. I also led the Political Action Committee for San Diego to the largest percentage of members contributing for our size category in the United States. I was also a contributing editor to LAN (Life Association News) magazine, with a circulation of 145,000, on the subject area of health insurance.

I am a member of the National Association of Health Underwriters which has a membership of 9,000 members across the United States. I am program vice-president for San Diego and I am serving my second year as Vice-President of Legislation for the State (membership 1,000).

I am a RHU (registered health and disability underwriter) and have consistently qualified for the award for production of LPRT (Leading Producers Round Table).

I have been published in most of our industry's professional publications and copies of my articles are also available to you since they all deal with selling health insurance or AIDS and how that disease will affect our industry. By the way, I was nominated to President Reagan's Task Force on AIDS by each of the state legislators within my county of San Diego and by our two Republican Congressmen.

I have spoken to both NALU and NAHU's National Conventions on the subject of health insurance and the prestigious national meeting of MDRT (Million Dollar Round Table). I have spoken and given seminars at over 100 associations throughout the United States.

I have appeared numerous times on talk shows relating to this industry both on TV and radio. I have spoken to state and local meetings of the Medical Society and also CPA groups.

My presentation qualifies all participants for continuing education credits for both insurance agents and CPA's in several states. I am also a speaker for my other industry's professional associations: Big I (Independent Agents Association) and the PIA (Professional Insurance Agents). Both of these organizations are mainly oriented to property and casualty insurance. I also speak to IAFP (International Association of Financial Planners).

I serve as the chairman of the Health Advisory Committee for State Senator Stirling, have served on the Health Advisory Committee for U.S. Congressman Bill Lowery (R), and am presently on the Health Access Committee for the local Medical Society.

I have been on the executive committee for fund raising for state Senators Ellis (R), Stirling (R), and Debbah (D) and the clubs for Assemblymen Killea (D), Chacon (D), and Bentley (R) and Lowrey (R) and am an active participant as an advisor for health insurance related questions to the state legislators on an informal basis.

Professionally, I have acted as a consultant to AMI (American Medical Internation Hospital) to create an insurance package tp be marketed in the state of California. I consulted with Golden Eagle Insurance Company regarding a small group insurance product. I am also consulting with the DOC Corporation which is a group of doctors in San Diego county that are creating an insurance company to sell health insurance to small groups and individuals.

As you can see my background is diverse yet highly specialized in this one area of my insurance industry. For these reasons, I feel I was contacted by Senator Kennedy to be an expert witness on the small group marketplace and the agent's role in the distribution system for health insurance.

As Mr. Nexon wrote in his invitation letter to me on June 12th, "I am particularly pleased that you will be able to inform the Committee about the important role played by the agent. Every time I have seen you, you have presented a perspective not familiar to most members of our Committee."

Therefore, I am representing my own personal views regarding this subject but I know that I speak for thousands of insurance agents throughout the United States. I have made my views clear when I speak, write, or represent myself to any group. the agent does a unique job.. Our clients know who we are and they recognize the imporatnace of our being advocates for our insured. In health insurance we do not work for an insurance company, we work for the client. On his behalf we go to the marketplace to find coverage. Persistency in health insurance means persistency with your client--not with an insurance company. The service we provide cannot be replaced by beauracy from either monolith insurance companies or government.

Clearly, our role from my perspective cannot be eliminated. I therfore, strongly present my case that no matter how we solve the problem of access to health care for Americans the insurance agent should be the distribution system.

It seems the first tier that is cut out of a system is the agent--in order to save money. Insurance companies think they can do it with just their employees and the government thinks they can do it with their employees. But in both these cases the personal relationship and caring that the agent supplies will not be duplicated. Don't shoot the messenger, as I said in my testimony, for the loss of this individual means the loss of a system that truly works on behalf of the insured.

Question 3

COBRA coverage is without a doubt one of the most popular mandates among individual Americans. This requirement allows employees of companies to move from one job to another without the fear of losing their insurance coverage immediately. Because ongoing claims or planned surgery or even pregancy cannot be denied nor interrupted, this transition coverage is invaluable to the individual insured. Even if insurance coverage were more aforable the time limit on COBRA would be insignificant. Most individuals that are healthy and not in the high age bracket can get an individual policy for less money than their former group plan. So, affordability does not relate to the time period. What is significant is the use of an insurance plan without pre-existing waiting periods or limits on coverage.

Therefore, I would say that the shortening of the time limit on COBRA would not be a popular idea with individual workers that qualify for this mandate now.

Question 4

I definitely support the development of risk pools for the uninsurable. I believe that each state should set up an insurance risk pool that allows individuals that cannot find insurance coverage to buy a plan. "Uninsurables" are individuals that have one of the "Big Five" conditions that I referred to in my testimony. However, there are many other conditions for which insurance companies will either rider-out, or exclude, or refuse coverage entirely. In these cases individuals have no recourse and they go without any coverage.

If each state had an uninsurable risk pool then these individuals would become insured. The cost for covering such a pool would be far more expensive than the regular marketplace. This pool would serve those that need more expensive policies.

As I stated in my testimony, there are three types of uninsured. The healthy uninsured can easily obtain coverage through individual policies. They must be responsible for paying their insurance even though they may feel they are healthy and nothing will happen to them.

The working poor are individuals who simply cannot afford to pay premiums for insurance and so go without coverage. Whether they have a good health history or a poor health history, insurance is a moot point because of afforability.

The "uninsurables" are the unfortunate ones because they simply cannot qualify for a full coverage policy and are forced to go without insurance even when they could afford to pay the premium.

Therefore, these uninsurable risk pools are, in my option, a must in America. No matter how we solve the problem of access to health care for Americans, individuals that are not covered through their employer need access to insurance coverage. That access to coverage can be provided requiring states to have risk pools for the uninsured.

In response to your question regarding agents administering these pools, I would like to clarify that agents are licensed to sell and service, but administration is not part of that process. Insurance companies pay claims, create billings, pay commissions, and do all areas of administration and contract negotations. I would think the states can do the administration of the risk pools but the agent is not involved in that process. I will take this opportunity again to state my case that the agent should be the distribution system for any state-run risk pool. Let the product be sold by the licensed insurance agent and the system will work.

NFIB

National Federation of
Independent Business

June 28, 1989

Senator Edward M. Kennedy
Senate Labor and Human Resources Committee
United State Senate
Washington, DC 20510

Dear Senator Kennedy:

Enclosed find NFIB's testimony regarding S. 768 for submission into the hearing record of June 23, 1989.

Thank you for the opportunity to comment on legislations. At the next available time, we would appreciate the opportunity to present oral testimony on this issue.

Sincerely,

John J. Motley III
Director
Federal Governmental Relations

7676D

Enclosure

Suite 700
600 Maryland Ave. S.W.
Washington, DC 20024
(202) 554-9000
FAX (202) 554-0496

The Guardian of
Small Business

SUBMITTED
STATEMENT
OF THE
NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Before: Senate Labor and Human Resources Committee
Subject: S. 768
Date: June 28, 1989

NFIB is a voluntary membership organization with over 580,000 small business owner members. Our membership comes from all of the industrial and commercial categories and reflects the national small business community in its distribution among industries. That is, we have about the same percentage of members in the construction industry, the manufacturing industry, wholesale, retail, etc., as exists in the national business profile.

For NFIB members and their more than 7 million employees, much is at stake in the current debate over mandating health benefits.

While NFIB is a recognized authority on small business, NFIB is not an expert in the health care industry or in the insurance industry. Therefore remarks are primarily directed to a description of the attitudes and operational characteristics of the small business community that are relevant here.

NFIB has conducted three national surveys in this general area. The first was done in 1978 and is entitled National Health Insurance Report on Small Business. The second, conducted in late 1985, is entitled Small Business Employee Benefits. A third is in the process of being thoroughly analyzed; however, the preliminary results are very interesting and are shared later in this statement. In addition, the rising cost of health insurance was the number one problem as first reported in NFIB's 1986 Small Business Problems and Priorities. It was also one of the top concerns raised by the 1986 White House Conference on Small Business.

MANDATE Results

NFIB constantly polls its membership. No position on legislation is taken without approval of a majority of the membership. On the issue of health insurance and health care, small business owners have been loudly registering their concern over the focus of the debate. Mandates, massive expansion of federal government programs, national health insurance, and Canadian system mimicry ignore and exacerbate the real problem for small business--rising health insurance costs.

In April 1987 an overwhelming 89% opposed mandated health insurance (7% favor, 4% undecided). In 1989 small business owners again registered their overwhelming opposition to mandated health insurance legislation.

Our research consistently confirms that the number one problem facing small businesses is the cost of health insurance. This conclusion was evident in 1986 when out of seventy-five issues polled (from taxes to unemployment compensation to utility rates) the cost of health insurance ranked *number one* – even above liability insurance, which was at that time in a crisis state. The problem remains at the top in 1989. In fact, in the newest NFIB comprehensive health study, an astonishing 89% listed heatlh insurance as becoming *prohibitively* expensive.

Background

The United States spends an enormous amount of money on health care. In 1987, almost $544 billion was spent on health care, or an average of $1,926 per citizen – a significant increase of 8.9% over 1986 – amounting to 11.2 percent of GNP. A number of health analysts predict that as much as 15 percent of GNP could be spent by the year 2000, a huge increase, especially considering that in 1950, only 4.4% of GNP was allocated to health care. No other industrialized nation dedicates as much of its GNP to health care as the United States. Expenditures make U.S. health care the largest American industry – far surpassing education and defense expenditures. Only the deficit accounts for a larger percentage of funds.

This trend reflects the spiralling increase in health care costs over the past three decades. Since 1966, health care costs have increased three times faster than the consumer price index, and even more astonishing, health care inflation during the past year has topped 7%. Inflation, however, is not the only culprit. A recent US Department of Health and Human Services study indicated that "35% of the increase in total dollars spent on health care was attributable to the consumption of more service per capita and a higher intensity of service in each contact."

Health insurance premiums are also rapidly increasing. A Foster Higgins survey indicates that the average cost per employee for all companies (includes large and small) was $1,985 in 1987. By next year, they estimate that cost will be $3,273. Obviously, individual company premiums will differ based on size, region, experience rating, sex of employee, age of employee, and richness of plan. But overall health benefits represents 36% of payroll costs for a part-time minimum wage employee.

S. 768 and its counterpart in the House would exacerbate this situation in three direct ways: first, by increasing consumer demand for health care by providing access to care at below-market price; second, by forcing the nation to make an even greater commitment of resources to health care, thereby diverting resources from other areas of the economy; third, by shifting a societal problem onto the employer community; and fourth, by driving up health care costs for American businesses, particularly small businesses, hurting their competitiveness and job creation potential.

Small Business and Health Insurance

To understand our unconditional opposition to mandated health insurance coverage, a little historical background is valuable.

The 1986 survey by the NFIB Foundation, entitled Small Business Employee Benefits, revealed that the number of small business owners providing employee health insurance had steadily increased since 1978. The 1989 survey reveals that coverage has since stabilized. In 1989, as in 1986, sixty-five percent of small businesses offered health insurance for at least some full-time employees.

Increases in the coverage rate since 1978 have been most notable in firms involved in financial services, professional services, retail, and the smaller firms -- the very same firms held responsible for the alleged increase in the uninsured population. The troubled, and difficult to insure, agricultural sector continues to be the only sector that has reduced coverage. NFIB field survey data from April, 1987 indicate as many as seventy-five percent of those members providing fringe benefits are providing health insurance. This is despite the fact that in 1985, the median monthly health insurance premium paid by small employers was more than double the premium in 1978 and at least 20% lower than premiums today.

Small businesses tend to offer a hierarchy of benefits which expands as the firm matures and increases in size. Small business owners as a group provide their employees with a wide variety of benefits, paid vacations and health insurance being the two most commonly offered. In addition, larger small firms are most likely to provide a wider selection of benefits to a larger number of employees than are the smallest firms.

Well over 80% of the health insurance plans offered in small firms carried an option for dependent coverage; however, fewer part-time employees were offered coverage and usually only after a vesting period with the firm. The majority of small firms offering coverage paid 100% of the premium costs, in sharp contrast to their much larger corporate counterparts.

No single reason dominates a small firm's decision not to offer health benefits. The most frequently cited reasons for not providing health care coverage to all employees were: premium expense, employee turnover too great, generally covered under a spouse or parent policy (secondary wage earners), firm insufficiently profitable, and cannot qualify for a group policy. The latter two received the heaviest response rate in the 1989 study.

Small Business In 1989: Preliminary Survey Results

In 1986, NFIB first identified the cost of health insurance as the number one problem facing small business. When asked in 1989 whether the "cost of health insurance is a serious business problem," 66% strongly agreed; an additional 26% agreed with that statement. In addition, 89% found health insurance becoming prohibitively expensive, and respondents offering health insurance had seen increases in premiums in the past year.

Contrast the above to some of the attitudes held by small business owners. First, seventy-one percent believe that every American has a right to basic health care; 74% believe that Americans should receive a minimum level of health care, regardless of their ability to pay. It is at this juncture, however, that small business owners part company with many policymakers in Congress. Small business owners do not support mandated health benefits for businesses or even those directed at individual purchasers. They also do not support raising taxes to increase access to health care for low income individuals, much less for the 38% of uninsured individuals who reside in households earning $20,000 or more a year. Since 1978, a consistent finding has been that small business owners believe individuals have the first responsibility to see that they have health insurance coverage.

The cost of health insurance is posing a serious dilemma for small firms. Many believe that increasing costs are (or will) make it difficult to compete, and only a minority believe that such costs can be fully passed on to the consumer. Small firms are also discovering that employees prefer wage increases to benefit increases. The younger or more part-time the firm's workforce, the greater that preference. In addition, the majority of small business owners do not believe that they have lost good or potentially good employees because of inadequate health benefits. These mixed signals, coupled with dramatically increasing costs and low business profitability (over 40% reported that they could earn more working for someone else), do not bear out much hope for encouraging small firms who do not currently offer insurance to do so. Market pressures and employee preferences do not appear to be driving forces in deciding whether to provide insurance.

Preliminary analysis of the 1989 survey has raised two other interesting features of the small business health insurance market. First, most small business owners do not believe that insurers aggressively compete for their business. Second, of those who do not offer coverage, many independently responded that they were "too small" to get coverage. As in the past, it appears that small firms remain the stepchildren of the insurance industry. High overhead and marketing costs make the small business sector an undesirable target. It is also difficult to fashion cost containment packages for small firms because of the unique dynamics of a small company, such as adverse selection, employee turnover, and inability to self insure.

Any downturn in the economy will also have a significant impact on the availability of health insurance as a fringe benefit. Our data strongly suggest that the offering and/or "richness" of this fringe benefit is directly related to business profitability.

Clearly, the policy solution lies with incentives--for both individuals and for small firms unable to afford coverage. Sixty-two percent of small business owners support the government taking a more direct role in bringing health costs under control. Incentives may be the key to unlocking the problem of premium costs; the problem of health care costs lies elsewhere.

Small Firms and Unaffordable Health Insurance

Providing health insurance is much more costly to small firms than to their larger counterparts. By their very nature, small firms are labor intensive and employ many part-time employees. In addition, most small business owners have lower median incomes than wage and salary earners. Clearly, the fat has been trimmed.

Several external factors enter into the equation in determining insurance coverage. First and foremost, small firms are generally unable to self-insure, thus they are forced to operate under the rubric of costly state health insurance mandates. While discussed later in this statement, state health insurance mandates drive up the cost of health insurance for firms that purchase in the open marketplace and preclude the offering of "barebones" insurance policies. The lack of affordable "barebones" catastrophic insurance keeps both small firms and individuals out of the market.

Second, according to recent Health Insurance Association of America (HIAA) estimates for 1988, premiums in small firms run 15 to 25 percent higher than those of large, non-self-insured firms. The Small Business Administration estimates that administrative costs for small firms can be as much as 40% higher than their larger counterparts.

Third, more than two-thirds pay the entire premium, and a whopping 87% pay more than half. Small employers are also more generous than large employers when family plans are offered. According to the Small Business Administration, of those firms offering family health insurance plans, 70 percent of the very small firms (1-9) and 55 percent of 10-24 employee firms, but only 34-35 percent of larger firms, pay the entire premium for family coverage.

Fourth, the cost/benefit ratio for small firms is also skewed against small firms. Of each $100 paid in premiums, small firms derive only $75 in benefits, whereas large firms receive $95 (Nexon, 1987). The reasons for such a differential in both the benefits ratio and higher premium costs include: lack of economies of scale, cost of administration, insurer fear of adverse risk selection, instability in the firm, and the lack of expert help in selecting insurance plans.

Fifth, HMOs and managed care systems are not aggressively marketed to the small business sector for many of the reasons outlined above and because small firms tend to be very traditional in their choice of health care providers. Thus marketing requires a greater basic educational effort. Compounding the problem is a plethora of state laws restricting HMOs.

Finally, cost containment practices also are not prevalent in small firms. Some common methods used to control costs, such as higher deductibles and/or inclusion or exclusion of employees after a probationary period with the firm, are eliminated by S. 768. Under S. 768, deductible levels are frozen, as is the maximum out-of-pocket cap and copayments. All employees must be covered, vesting periods are prohibited, and benefit levels and types are permanently set.

The problems with the startup, marginal, and "high risk occupation" firms are also important factors in determining the ability to obtain health insurance. Underwriting practices routinely exclude these firms or refuse to offer "discount" group rates.

The Marketplace

The current system of providing incentives has worked. In 1940 little over 40% of Americans were covered by health insurance. Today over 84.7% are covered. That is an accomplishment.

NFIB believes that the crisis of the uninsured cannot be fixed by simple solutions because the cause is so complex. Pure and simple economic growth accounts for a portion of the uninsured pressure. The 1980s has been dubbed as the decade of the entreprenuer. There have been record business startups each year. Over 19 million new jobs have been created, mostly in small firms. By definition most of these new businesses are marginal; well over 50% fail in the first three years. There have also been record high numbers of new job force entrants, many of whom are women. This very same decade has seen increased health insurance premiums and health care inflation far outstripping consumer inflation. All of these factors are important in analyzing the problem of the uninsured.

Clearly the surge of growth in new businesses and jobs has temporarily outstripped the business community's ability to provide health insurance. We believe that the problem will ease – the now new firms will stabilize and the workforce will expand less rapidly.

The first decade of the 21st century also ushers in a dramatically different scenario: tight labor market, maturing workforce, potentially lower skilled general labor force, and increased foreign competition. These forces will have a positive affect on the continued expansion of health insurance, as small firms will have to compete with big powerhouses to attract and retain qualified workers. Changing demographics and workforce, coupled with new incentives and a redirecting of federal funds, should adequately address the issue of the uninsured without instituting wholesale changes in our health care system.

A Solution: Cost Containment, Development of Incentives and Removal of Barriers

As mentioned previously, the system of incentives has worked. This Committee should consider expanding the incentive approach in the following fashion:

1. The tax laws give a distinct advantage to the business owner who operates in the corporate form as opposed to the business owner who operates as a sole proprietor or partner. In the corporate form, the owner's full health insurance costs, as well as those of his employees, are deductible as business expenses. For the self-employed, only the health insurance costs attributable to the employees are fully deductible.

The Tax Reform Act of 1986 made a move in the right direction by allowing 25 percent of the cost of the self-employed business owner's health insurance costs to be deductible. However, this partial, and now targetted for extinction, deduction denies the self-employed business owner the incentives given to the corporate business owner to obtain health insurance him/her and the firm's employees.

According to a 1985 study by the Employment Benefits Research Institute (EBRI), 22.4 percent of self-employed business owners carry no health insurance. These business owners make up between six and sixteen percent of all uninsured workers. Full deductibility, therefore, would address a significant portion of the health insurance gap that exists simply by equalizing the treatment for incorporated and unincorporated businesses.

2. Provide a tax deduction or credit for individuals to purchase their own health insurance. The credit/deduction should be targetted to low income families with children. While access to health care has developed into a right, it is not the obligation of the employer to ensure that right. Individuals, attached or unattached to the workforce, should be provided with assistance in affording the purchase of health insurance. The deduction should be limited to premium assistance and be available regardless of whether a taxpayer itemizes or meets a threshold.

3. Allow for a partial refundable tax credit or payroll tax credit for the cost of the benefit for small employers who provide health insurance. This type of deduction would be targetted toward the sizable number of small firms who do not have taxable income and hence are unable to take advantage of the current deduction.

In addition, a whole range of other problems occurs with the disincentives currently in place in the law. Appendix 1 illustrates this point.

1. State health insurance mandates. Clearly, the most troublesome disincentives are the cost of health insurance and health care. One relatively simple way to lower health insurance costs is to preempt state health insurance mandates. State mandates for specific types of benefit coverage now number over 690. These state mandates have seldom surfaced as a result of constituent demand, but rather have been initiated by well-organized special interest groups, including the providers of services themselves. State mandates range from coverage of wigs (MN) to herbal medicine (FL) to in vitro fertilization (proposed-OH) to special diets for people with Crohn's disease (Mass). Together, they preclude the offering of "barebones" affordable policies for non self-insured companies--the majority of whom are small businesses.

The end result of benefit mandates has been a remarkable growth in the number of providers performing the mandated service -- providers who suddenly find that payment for all services is available, indeed mandated, by state law. In Wisconsin, the passage of a mental health mandate resulted in a phenomenal rate of growth in the number of outpatient mental health clinics -- from less than 40 to more than 900 in ten years. A similar mandate is contained in S. 768.

In Maryland, state mandated insurance benefits were estimated to raise the combined average cost of group and individual Blue Cross/Blue Shield coverage by more than 11% in 1984; outpatient mental health benefits alone were estimated to raise total plan costs by more than 4%. Current estimates tag that increase near 20%. Mandates eliminate the cost control mechanisms provided by comparative choice and increase the cost of health services.

Benefit mandates make coverage prohibitively expensive due to the legislative dictates of the package's components. They take away the right of the insurance purchaser to select and pay for coverages based on the needs of the workforce and the ability to pay. Buyers end up spending scarce resources on benefits that they may not want or use, or reducing coverage for more essential health services in order to accommodate the extra costs associated with mandates. S. 768 with its "well baby" and "mental health" provisions is headed down this costly path.

2. COBRA. At a minimum, reform of COBRA is also necessary. Simple changes, such as requiring election of continued coverage two weeks after termination of employment, increasing the administrative fee to reflect actual costs, changing dependent coverage requirements to preserve the status quo rather than providing an independent right to enhanced coverage, and quarterly advance payments would go a long way to helping relieve some of the costly burdens COBRA has placed on small firms.

3. Costs. All involved in the health care field bear some responsibility for the escalating costs, including individuals who are no longer purchasers, but simply middlemen between the health care provider and the insurance carrier. Active consumer participation is necessary to control costs and regulate service usage. In addition, the issue of the burden of uncompensated care in non-profit hospitals must be balanced against the billions of dollars of foregone local, state, and federal tax revenue. This forgiven tax burden is borne by the rest of the business community. In return for such enormous tax relief, hospitals have willingly entered into social compact to provide charity care, and that obligation should not be assumed by the federal government.

Protocols and liability/malpractice tort reforms should also be examined as part of the solution to drive down the cost of health care. Cost containment is the cure for the disease of limited access to quality health care. With effective cost containment, the symptom of the uninsured will be treated.

S. 768

Once again, NFIB reiterates our membership's strong opposition to mandated health insurance benefits. This bill is the mandate to beat all mandates -- its potential for destroying small firms, stopping job creation, and socializing our health care system is enormous. A mandate simply places a cap on the thriving sector of the economy, yet permits health care costs to continue to escalate wildly.

One obvious impact of higher health premium costs will be less monetary compensation for employees as small firms shift funds from cash compensation or other fringe benefits to health insurance premium payments. Another consequence of increased payroll costs could be a reduction in the size of the firm's workforce, with part-time, lower skilled, and/or entry level positions cut first. Such workforce reductions would particularly hurt the lower income, women, students, and elderly who are employed in large numbers by small businesses. Finally, several general business community surveys have indicated that 70-90% of all firms would have to change their plans to meet the high standards of S. 678. Actuarially equivalent language offers no respite.

The S. 768 plan removes all of the current cost-contaimment mechanisms currently available to a small firm -- flexible copayments, deductibles, and caps. Under S. 768, these are frozen in time.

Payments are guaranteed to insurance carriers, and later to doctors and hospitals, with no attempts to control the prices or use of those services. The public program will also invoke huge outlays of revenues, inferentially to be derived from new or increased taxes, and has the potential to compete with private industry. The public plan also attempts to cover the entire uninsured population, but a significant portion of those are in households earning over $20,000 or are individuals who should be covered by the intended scope of Medicaid.

To the author's credit, the small business provisions attempt to address some of a the unique problems small firms face.

Unfortunately, the small business provisions do not begin to alleviate the burdens S. 768 would thrust on the small business community. The bill itself acts as a significant disincentive for expansion and entrepreneurial activity. The part-time provisions will also jeopardize the continued offering of part-time provisions. In fact, the subsidy provisions are regarded as an implicit admission to the extraordinary costs and adverse impact this bill would have.

The only way to help small firms obtain and retain health insurance is to provide incentives. A mandate is an enormous burden which not only dramatically alters the way fringe benefits are provided in this century, but it does not solve the real health care problems nor significantly reduce the number of uninsured Americans.

Conclusion

There are ways to encourage coverage other than mandating the expansion of health insurance coverage to employees of small firms. A better alternative is to put small business on a footing more equal with their larger competitors -- equalize the health insurance premium deduction for the self-employed business owner, provide equal protection from state benefit mandates, explore the development of workable incentives to small firms including expanded tax incentives, and remove government-erected disincentives to providing coverage.

Much of the problem, though, is structural. First, we have just been through a period of record numbers of new business startups. Marginal firms and firms that leave the marketplace make up a significant portion of the small business community, roughly 20% at any given time, who are unable financially to provide significant fringe benefit packages or unable to obtain coverage because of their insufficient or nonexistent experience rating.

Second, the data we have indicate small employers provide health insurance benefits when they are financially able. Small firms are responding to workforce pressures to provide benefits comparable to large corporations. The small firm, however, must be given the flexibility to phase in those benefits as the firm matures, as it becomes more profitable, and as the employees demand such benefits.

I would reiterate that small employers continue to offer health insurance, but it must be kept affordable for small firms to retain and expand coverage. Small firms are one of the true victims of the health care cost crisis. The paternal instinct to provide for their employees is alive and well; however, many small firms are precluded from acting on it because of the costs of health insurance. Cost is the problem, actually the disease. S. 768 simply attempts to overmedicate the unfortunate symptoms.

AMERICAN ACADEMY OF ACTUARIES

SENATE LABOR COMMITTEE
HEARING ON KENNEDY MANDATED
EMPLOYER-PROVIDED HEALTH BENEFITS PROPOSAL

STATEMENT FOR THE HEARING RECORD
THE COMMITTEE ON HEALTH
AMERICAN ACADEMY OF ACTUARIES
JULY 6, 1989

The American Academy of Actuaries is a professional association representing actuaries in all areas of actuarial practice. Members of the Academy's Committee on Health who prepared this statement are employed both as consultants and by insurance companies. For purposes of this statement, however, we speak as professional actuaries and not on behalf of our clients or employers. The Academy and its committees do not advocate public policy positions that are not actuarial in nature. We view our role in the government relations arena as providing information and actuarial analysis to public policy decision makers, so that policy decisions can be made on the basis of informed judgment.

The Academy regards the lack of health insurance coverage for approximately 31 million Americans (according to a recent Census Bureau estimate) as a very grave social problem. We have reviewed the proposed Basic Health Benefits for All Americans Act of 1989, S. 768, that would require most employers to provide health insurance to their employees and their dependents up to minimum standards. As a professional association, the Academy neither supports nor opposes legislation mandating employer-provided health insurance. We commend Senatory Kennedy for recognizing that to cover all uninsureds both the public and private sector programs must be expanded with a subsidy provided to small businesses to ease their financial burden. We would like to indicate some potential problems with the regional community pricing mechanisms and richness of benefits proposed in Title III of S. 768. We also would like to make known why costs for small group employer coverage are much higher than for large group employer coverage.

Community Rating

The community rating concept pools all entrants of a particular class together to pay the same rate for the same level of benefits. In the case of this bill the particular class is the small group class (under twenty-five employees). The principle works and is good as long as there is a good cross section of risk in such a pool, i.e., a good cross section of high- and low-user groups. Requiring insurance carriers to provide small group health coverage on a community-rated basis can cause problems in several ways. The underlying problem with community rating is that it does not reflect variation in health care costs due to factors such as age, industry, and geography. In general, good risks avoid or drop out of a community-rated pool, leaving behind the poorer risks for whom community rates are a good buy. This situation would require either further rate increases or a considerable drain on a company's surplus to compensate for the inadequacy of rates for the remaining risks. Even increasing rates may be ineffective, for doing so may stimulate a further round of groups dropping out. This typically leaves an even poorer cross section of risks in the community pool, requiring even higher rates. This process, referred to as an "adverse selection spiral", is very familiar to life and health insurers. It could make the costs of some competing regional carriers spiral out of control, while the costs of other carriers (who have attracted more favorable health risks) remain affordable. This process has been a prominent feature of the operation of the Federal Employees Health Benefits Program.

The advantage of community rating to the regional carrier would be the relative ease in administration, but the disadvantage to the carrier is that groups with good experience would tend to cancel and re-enroll with another regional carrier if the rates were lower. The advantage to the group is that there are no drastic rate fluctuations because the low-user groups support high-user groups. However, while high-user groups are satisfied, the low-user groups would tend to cancel.

S. 768 allows actuarially equivalent plans, at least with respect to variation in copayments, deductibles, out-of-pocket limits and employer contributions. This feature would appear to encourage competition among regional insurers. This should facilitate groups moving from insurer to insurer. The down side of this is that community-based rates may prove inadequate and an insurer may face solvency problems.

Existing small groups will be allowed to keep their coverage with their current carrier. These small groups would be below average cost since they would not include uninsurable groups, and at present are satisfied with the cost of insurance for the benefits provided. However, those groups without coverage, and existing groups that cancel their coverage with the current carrier, must do business with one of the regional carriers. These groups will have risk characteristics that are much worse than the aforementioned groups which have coverage through their present carrier.

Secondly, there could be a large amount of anti-selection between carriers because of cost differentials by area (rural versus metropolitan) as well as by state. Large cost differentials among groups with differing profiles of age, gender, and (to a lesser extent) family size could also contribute to such selection. Finally, there would be an inordinate amount of selection within a carrier between the high- and low-option benefits that must be offered. This belief is based on the fact that the characteristics of the small group uninsured population are largely either (1) unaffordability or (2) uninsurability. Therefore, those groups that cannot afford insurance would choose the low-option, lowest-priced coverage, while the groups that can afford premiums would, in most cases, choose the high-option coverage. Because it is to their financial advantage, uninsurable groups would also tend to choose the high-option coverage.

While a better than average cross section might be attainable on the respective low options, this would not be the case for the high-option coverages, making the price of the high-option coverage too costly. This would cause some of the better risks of the high-user groups to transfer to another carrier or even to a low option, causing the costs for the high option to spiral, and perhaps eventually become unaffordable.

Charging each group a premium that represents its risk level may not be a viable solution since premiums for high-risk industries in high-cost geographic areas can be many times the premiums for low-risk industries in lower-cost geographic areas. Since this system may make coverage prohibitively expensive for some groups, the objective of making insurance accessible to all groups may not be achieved.

One way of mitigating this problem would be to allow some form of subsidy for high-risk groups which would keep premiums from being higher than a certain percentage over standard rates. Alternatively, companies could be allowed to rate groups by class (similar to federally qualified HMO's) to reflect their risk and geographic cost level, also limiting rates to certain ranges, thereby avoiding substantial cost variations. High risk groups could be shifted to a high risk pool. In addition, allowing phase-in of the preexisting condition prohibition would help mitigate the antiselection.

Richness of Benefits

The package proposed by the Kennedy/Waxman bill is comprehensive, including the outpatient psychiatric addition. For small groups that supposedly could not afford such coverage, the benefits are rich with a handsome price tag attached. This bill, in fact, counteracts cost containment efforts in other areas and would tend to increase health benefits as a proportion of the gross national product as utilization will certainly increase for this segment of the population.

The maximum limitation for deductible of $250 (single contract) and 20% coinsurance up to a limit of $3,000 out-of-pocket expenses (uncertain whether for single or family) as a low-option benefit program limitation, with lower deductibles, coinsurance, and out-of-pocket expense limitations for the high-option benefits, would not be conducive to reducing the escalation of health care costs.

The introduction to S. 768 in the Congressional Record suggests that managed care could reduce claim costs by 15%. While such reductions have been achieved in managed care programs on a local basis, managed care savings are typically much less when averaged over wider geographic areas. A recent national survey indicates that initial savings due to managed care amounted to only 4% to 5% of claim costs in the first program year, with savings in following years dropping around 1% (i.e., to 3% to 4% of claim costs). These savings do not reflect the increased costs needed to administer the managed care program, which amount to about 1.5%. Thus, based on this survey, net savings from managed care over broad geographical areas would typically amount to around 2.5% to 3.5% of claim costs in the first year of the program, falling to 1.5% to 2.5% of claim costs in following years.

We suggest that regional insurers be permitted to offer only low option benefits (i.e., the minimum benefits proposed in Title III) for a start in order to hold down the costs for both employer and employee.

Coordination of S. 768 with State Insurance Regulation

S. 768 extends the ERISA preemption to any state insurance laws or regulations "relating to contracts or policies of insurance issued to or under a health benefit plan under Title III of the Basic Health Benefits for All Americans Act." [Title I, section 202(a)(2)(C)] This provision clears the legal and regulatory ground for Title III to require health benefit plans to meet certain coverage, benefit design, and other requirements. However, the scope of the ERISA preemption raises questions about the role intended by S. 768 for state regulation of insurer financial solvency, and other issues. For example:

1. Will state insurance regulators still have any responsibility for rate regulation in the large (over-25-employee) group health insurance marketplace?

2. How will S. 768 affect the operation of state guarantee funds protecting policyholders in case of insurer insolvency?

3. Are state premium taxes on health insurance premiums to be eliminated?

4. Are even premium taxes earmarked for solvency guarantee funds to be eliminated.

5. Would S. 768 prohibit allocating state income, or other non-premium, taxes to the health benefit plan segment of the business?

As the above questions indicate, the ERISA preemption in Title I may have been framed more broadly than the drafters of S. 768 intended. Some clarification (and, if appropriate, redrafting of the preemption language) would be helpful.

Higher Cost of Health Insurance for Small Groups

Factors contributing to the high cost of health insurance for small employers, as compared to the cost for large employers, include the following:

1. Smaller base of employees and premiums over which to spread various fixed expenses.

2. Higher claim level due to the unavailability of workers compensation for small groups in some states.

3. Certain adverse selection effects that remain even with pooling or community rating because of the greater variability of small group

risk cross section as compared to large groups.

4. Larger group avoidance of state mandated benefits, premium taxes, and risk charges by self funding (through claiming ERISA preemption of state insurance laws).

5. The high turnover of small-group employers who readily switch carriers because they are price sensitive. This entails a higher risk charge and faster amortization of initial expenses.

6. Various benefit management and accounting functions are provided in-house on a large employer's health insurance program. Since small employers cannot afford the personnel to perform these functions, they are performed by the insurer, and the additional costs are reflected in the small group's rates.

The above factors can readily add up to a substantial difference. These explanations are given not only to help better understand the difference between small and large group costs, but also to indicate that a regional insurer will most probably be unable to price the mandated products for small groups as cheaply as for large groups.

Estimated Costs under Title IV of S. 768

With respect to Title IV of S. 768 -- "Assuring Provision of Health Benefits to Under-Poverty, Near-Poverty, and Other Individuals," we agree that there is a great need for access to care. A rough estimate of initial additional taxpayer costs for the below-poverty-level persons coverage in 1991 is in the range of $9 to $10 billion annually for the 6 million persons in this category. However, note that the very presence of insurance could cause these costs to escalate rapidly especially in view of Title IV's lack of utilization controls and insured cost sharing. The Medicare program serves as an example of the kind of cost escalation that is possible over the years in a generous insurance program without (until recently) significant cost controls.

Conclusion

We appreciate the opportunity to comment on these issues. Our committee would be pleased to answer questions you may have about this statement or provide further assistance to your committee. Because of our experience in health care financing and insurance, we believe that we can assist you in identifying and weighing the merits of proposals to provide health benefits to the uninsured. We hope the comments presented in this statement will be useful in helping Congress to deal appropriately with this complex problem.

Edward J. Wojcik, Chairperson
Committee on Health
American Academy of Actuaries

LABOR COMMITTEE
Dirksen Senate Office Building
Room 430
Washington, D.C. 20510

June 23, 1989

By: Karin Allen
7807 Winterberry Place
Bethesda, MD 20817

Mr. Chairman and Membersof The Committee:

My name is Karin Allen. I reside with my daughter Elizabeth in Bethesda, Maryland. I am 48 years old.

I would like to speak on behalf of millions of American people who are without Health Insurance.

We, the People, as many as 40 million people, are pleading to be heard by the Honorable Respresentatives and Senators of the United States Congress.

It is terrible to be faced with an illness. It is unbearable to loose your health and also your peace of mind. To become ill, to incurr high medical and hospital bills without the benefit of health insurance is simply an intolerable burden.

Yet 40 million people, single people, families with children, most of them in full time working positions do not have medical insurance. Not only are they tormented by the illness of a beloved family member, but also by unrelenting bill collectors.

Citizens of this country have died in ambulances, were refused admittance to hospitals, because they were uninsured. They were not poor enough to qualify for Medicaid. They were not old enough to be covered by Medicare.

President George Bush wants a kinder, gentler America. I hope with all my heart and the hearts of 40 million people that the near future will be kind enough to give all people the right to obtain good comprehensive health insurance. I hope that legislation will be enacted which will give workers the right to continuous medical insurance.

At present there are many employers, who provide great benefits for their employees. No all people can be employed by these companies. Not all people remain employed by these companies.

Loosing or changing jobs can also mean changing health insurance plans. It can also be the beginning of a financial nightmare and has been just that nightmare for countless people.

Oftentimes there is a 3 to 6 months wait to become eligable for company health insurance. Even though laws have been enacted to enable people to continue their coverage at group rates until their new insurance starts, many families simply do not have the money to pay 300, 400, or 500 dollars per month in premiums, which used to be paid by their employer; or at least 80% of that premium.

The stage is now set for the possibility of complete financial ruin of that family. Even if the new job offers health benefits from the beginning, 90% of the time, there are waiting periods for preexisting conditions. This is perhaps the worst offender, rendering millions of people, including myself uninsured.

I had spinal surgery in 1980. Our company's insurance carrier excluded benefits for any problem related to this preexisting condition for 10 months. Other carriers require 12 months, some even 2 years As of October 1988, any new employee, our company would hire, will have to answer health questions, and any preexisting conditions, he or she may have will be permantly excluded. This is so, simply because we are a small group with fewer than 9 employees. Please see copy of letter.

However, during the 10 months waiting period, I was considered uninsured by my Neurosurgeons office and was told, "that George Washington University Hospital would not treat me and that I would have to go to D.C. General in case of a problem with my cervical spine."

Our group coverage became effective November 1, 1987, and the waiting period for preexisting was over Septemver 1, 1988. On November 30, 1988, I was admitted into the Emergency at GW with a partially paralyzed right arm. I had surgery on December 7th, 1988. The total cost of this emergency with follow up physical therapy was almost 24.000 Dollars.

Had this happened to me prior to September 1, 1988, not one single penny would have been covered by our insurance.

How do people deal with this type of crisis? How do they relax, think happy thoughts, concentrate on healing, when they have a huge medical debt hanging over their heads?

These waiting periods are bad enough, however, if the current industry trend continues to permanently exclude preexisting conditions, then I am afraid, there will be many more uninsured people in this country.

I have had waiting periods and exclusions three times since 1981. Each time I could not afford a secondary insurance. Each of those 10 months have been an agonizing experience, depriving me of needed medical care and at the very least good physical therapy.

Premiums for Health insurance are rising at an alarming rate. Benefits are being reduced and ever larger copayments are required by patients. There are new policies implimented, which require a 20% copayment across the board for each medical and or hospital bill. At the time this is happening, Medicare recipients are fortunate enough to have catastrophic illness protection.

The answer to these problems can only be found in carefully planned and executed plans which require and enable all full-time and even part-time working people to have access to health insurance at a reasonable cost.

After my first spinal surgery in 1980, I was denied major medical insurance by three large insurance carriers. After the latest surgery I am sure that I am considered uninsurable by most companies until I become 65 years old and eligable for Medicare.

If insurance carriers are being allowed to discriminate against workers with previous health problems in small businesses (fewer than 9 employees), where will I go after my employer, now 68 years old, retires? Where will be my safety net? I like working for a small company. After all, small companies are the backbone of the American business community.

The cover story of a recent Newsweek Magazine reported the plight of a company, who's health insurance was cancelled because of high medical costs of some members. The contract promised good benefits, but was cancelled when members actually got sick. It was reinstated after protest by that company, but the premiums were raised enormously. This is actually happening to people and it is very sad.

I believe that every person has the right to comprehensive, affordable health care.

It should be continuous.
It should not discriminate against age or previous health problems.
It is a Human right.

Please help to divise a more uniform system with benefits for all working people, and hopefully also consider the needs of the people who may be temporarily unemployed.

Last November on Election Eve, NBC's John Chancellor reported that over 70% of American people polled want some type of National or Universal Health insurance in this country.

Thank you most kindly for your attention.

Sincerely,

Karin Allen

Karin Allen

The **Chairman**. Dr. Lewin, we know you have come the longest distance, and Ms. Ramshaw-Reed. We appreciate very much your telling us the story from Hawaii. We wish you a safe trip back.

Dr. **Lewin**. Thank you, Senator, for the privilege.

The **Chairman**. Thank you.

We'll stand in recess.

[Whereupon, at 12:07 p.m., the committee was adjourned.]

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